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ABSTRACT

This document reports the hearings on bills H.R. 11317 and H.R. 11472, bills to extend for three fiscal years the programs of assistance under the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970. The programs include grants to the states, special grants for the implementation of the Uniform Alcoholism and Intoxication Treatment Act, and special project grants and contracts. Detailed statements and letters by numerous medical, hospital, nursing, community mental health, volunteer and alcohol and drug abuse organizations justify the value of such legislation. A document on the Funding Task Force Findings provides details on alcohol and drug abuse programming, current public funding sources for providers of programs and for clients, and private funds. National Health Insurance is discussed. Recommendations and issues for further exploration are listed. (KS)

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COMPREHENSIVE ALCOHOL ABUSE AND ALCOHOLISM PREVENTION, TREATMENT, AND REHABILITATION ACT OF 1970—EXTENSION

ED130209

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

SECOND SESSION

ON

H.R. 11317 and H.R. 11472

BILLS TO EXTEND FOR THREE FISCAL YEARS THE PROGRAMS OF ASSISTANCE UNDER THE COMPREHENSIVE ALCOHOL ABUSE AND ALCOHOLISM PREVENTION, TREATMENT, AND REHABILITATION ACT OF 1970

JANUARY 19 AND 26, 1976

Serial No. 94–74

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COMPREHENSIVE ALCOHOL ABUSE AND ALCOHOLISM PREVENTION, TREATMENT, AND REHABILITATION ACT OF 1970—EXTENSION

MONDAY, JANUARY 19, 1976

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2123, Rayburn House Office Building, Hon. Paul G. Rogers (chairman) presiding.

Mr. ROGERS. The subcommittee will come to order, please.

This morning the Subcommittee on Health and the Environment begins its consideration of H.R. 11317, legislation which would extend the authorities for formula grants to the States, special grants for implementation of the Uniform Alcoholism and Intoxication Treatment Act, and special project grants and contracts under the Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act for 3 fiscal years.

Alcohol abuse is a serious and dangerous disease. It directly afflicts more than 9 million Americans and affects another 50 million. Alcohol abuse has the potential to affect all of us, social drinkers and abstainers alike as we confront drunk drivers, affiliated family members, and friends.

It is vital that the subcommittee not delay in renewing these authorizations and we hope to have legislation ready for House consideration in the very near future.

I would hasten to add, however, that although we are considering a simple extension of these authorities, we intend to carefully consider any proposed revisions to the law.

Without objection, the text of H.R. 11317, and any similar or identical bills will be placed in the record at this point.

[Text of H.R. 11317 and H.R. 11472 follow:]

[H.R. 11317, introduced by Mr. Rogers on December 19, 1975, and H.R. 11472, introduced by Mr. Patten on January 22, 1976, are identical as follows:]

A BILL

To extend for three fiscal years the programs of assistance under the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. Section 301 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 is amended (1) by striking out "and" after "1975,", and (2) by inserting after "1976," the following: "$20,000,000 for the period beginning July 1, 1976, and ending September 30, 1976, $80,000,000 for the fiscal year ending September 30, 1977, $80,000,000 for the

fiscal year ending September 30, 1978, and $80,000,000 for the fiscal year ending September 30, 1979".

SEC. 2. Section 304(d) of such Act is amended by striking out the period at the end thereof and inserting a comma and the following: "$3,250,000 for the period beginning July 1, 1976, and ending September 30, 1976, $13,000,000 for the fiscal year ending September 30, 1977, $13,000,000 for the fiscal year ending September 30, 1978, and $13,000,000 for the fiscal year ending September 30, 1979.".

SEC. 3. Section 311(d) of such Act is amended (1) by striking out "and" after "1975,", and (2) by striking out the period at the end thereof and inserting a comma and the following: "$23,750,000 for the period beginning July 1, 1976, and ending September 30, 1976, $95,000,000 for the fiscal year ending September 30, 1977, $95,000,000 for the fiscal year ending September 30, 1978, and $95,000,000 for the fiscal year ending September 30, 1979.".

Mr. ROGERS. This morning, because of the embargo on the proposed budget for fiscal year 1977, the subcommittee will hear testimony from public witnesses only, and will call administration witnesses to appear next Monday, January 26th.

Today's witnesses in many ways are the most important part of the alcoholism prevention, treatment, and rehabilitation effort—they represent the people who actually do the work—the public educators, the counselors, the directors of the treatment programs. We welcome you and look forward to your input.

Our first witness this morning is an old friend of this subcommittee—Dr. Morris Chafetz, former Director of the National Institute on Alcohol Abuse and Alcoholism.

We welcome you, Dr. Chafetz, and are most interested in what you have to say as a public witness, and you may proceed as you desire.

STATEMENT OF MORRIS E. CHAFETZ, M.D., PRINCIPAL RESEARCH SCIENTIST, FACULTY OF ARTS AND SCIENCES, CENTER FOR METROPOLITAN PLANNING AND RESEARCH, THE JOHNS HOPKINS UNIVERSITY

Dr. CHAFETZ. Thank you, Mr. Chairman.

Mr. Chairman, as always, it is a pleasure for me to appear before this important Subcommittee on Health and the Environment of the Interstate and Foreign Commerce Committee of the House of Representatives. It has always been a pleasure because of the compassion, concern, and understanding this committee continues to express toward the alcoholic people of this Nation, and because of the courtesies which have always been extended to me. I am especially delighted with this invitation to appear before you on H.R. 11317, because it is the first time in 5 years that I may make statements and respond to questions without restrictions, without the imposition of bureaucratic and departmental rules, and free from the dictates of the Office of Management and Budget. It is a heady moment for me.

Mr. ROGERS. It is a good way to start the new year.

Dr. CHAFETZ. Yes, sir.

I do not appear, however, before this subcommittee as it examines the extension of the alcoholism legislation, determined to be critical and harsh, but merely to share with you in your deliberations how effectively the congressional intent has been served in this particular program area, and what are some of the directions that we should consider as we attempt to deal with this overriding national and human concern.

Prior to my departure from the Government, I shared with the Congress a list of the accomplishments and challenges which developed under my tenure as Director of the Institute.

I should like, Mr. Chairman, to submit for the record a letter and proposal that I sent to Secretary Mathews, on August 29, that I think will be important to the record.

Mr. ROGERS. Without objection, it will be made a part of the record following your verbal statement [see p. 12].

Dr. CHAFETZ. Thank you, sir.

Some of the accomplishments that require highlighting are, for example, the Uniform Alcoholism and Intoxication Treatment Act which recognizes alcoholism as an illness, and makes it a health and not a criminal issue, and has been adopted by 27 States, while 11 other States, although not adopting the Uniform Act, have made important modifications in their legislation affecting alcoholic people.

Then, too, there was an important increase in funding for alcohol-related problems during the years of my tenure. When the National Institute on Alcohol Abuse and Alcoholism finally became a viable entity in May of 1971, as a consequence of the passage of Public Law 91–616, the Comprehensive Alcohol Abuse and Alcoholism Treatment, Prevention, and Rehabilitation Act of 1970, the fiscal year funding for 1971 was $17 million. By 1974, the appropriations process and the release of impounded moneys provided the program with $218.5 million.

Furthermore, there is abundant evidence that there is a growing acceptance of alcoholism as an illness as measured by the increasing acceptability from insurance companies for third party payments. We know, too, that the reality that alcohol is a drug is being accepted by this Nation when measured by survey techniques as well as evidenced by broadcast and printed reports around this issue.

The release of the two volumes of the alcohol and health report by the Secretary of Health, Education, and Welfare to the Congress discussed both fundamental and new knowledge in the alcoholism field and they generated a great deal of public interest while they helped to synthesize research knowledge.

We have evidence that the social stigmas attendant to alcohol are lessening, which is measured by the 500 voluntary citizens and youth organizations which have become involved with the alcohol issues and problems of this Nation.

The interest in and increasing number of occupational alcoholism programs reflects some of the language of Public Law 91–616 which placed a legislative emphasis on early identification. Occupational programs have shown a tenfold increase by businesses to assist their employees. There are more than 100 institute-trained occupational consultants in all of the 50 States, with 275 programs serving more than 2.7 million persons. These occupational programs are reporting recovery rates, without job loss, of 80 percent.

The first alcohol and health report stated: "Among American Indians, the incidence of alcoholism is at an epidemic level—on some reservations the rate of alcoholism is as high as 25–50 percent."

Because, Mr. Chairman, we knew a good deal about alcoholism but nothing about what it felt like to be an Indian, we created Indian peer review committees. When I left the Government, there were more than 160 Indian-supported programs that were originated by Indians and were being run by Indians. An evaluative study of several of the major tribal groups indicated recovery rates of better than 46 percent. Interestingly enough, recent research shows that the metabolism of alcohol by Indians is no different than other ethnic groups so we better be prepared to do away with our stereotypes about alcohol and Indians.

In conjunction with the Department of Transportation's alcohol safety action program, the Institute supported the development of alcohol treatment programs at approximately 25 sites. These treat-

ment programs brought a rehabilitation focus to this law enforcement process for drinking drivers rather than a punitive approach.

Because of the absolute necessity for accountability for these programs and in order to guarantee credibility for this national effort on behalf of the alcoholic people of this Nation, a data collection system was developed and is in use for programs which service 80 percent of the clientele of federally supported programs.

Under the direct auspices of each State agency, a State prevention coordinator program was implemented and, as of May 1975, 49 prevention coordinator programs had been established to develop initiatives within the individual States in the area of prevention.

I might also add that we have involved important organizations such as the educational commission of the States, the JC's, PTA's, Federation of Women's Clubs, YMCA's, and so forth, and we will continue to need Government grants to maintain this leadership interest across the country.

The Institute also created the National Clearinghouse for Alcohol Information which serves as a national focal point for the collection and dissemination of a comprehensive body of knowledge on alcohol abuse and alcoholism. The Clearinghouse obtains worldwide information on alcoholism prevention and treatment, and shares this knowledge with the community and the general public. During its first 3 years of operation, the Clearinghouse has built a library and a reference system of more than 45,000 items while disseminating some 8.5 million information items across the Nation and throughout the world.

Furthermore, the Institute created in 1973 the National Center for Alcohol Education as a means to develop manpower related to the treatment and prevention of alcohol abuse and alcoholism. These are facts that I have shared with you before, but which bear reemphasizing in an era of cynicism about Government programs.

But I should like at this time, Mr. Chairman, to share with you some information that you have not previously had. For example, there are preliminary estimates which indicate a 7.4-percent reduction in cirrhosis deaths during the first 9 months of 1975, compared with a similar period in 1974. If these data hold up, we might cautiously begin to question whether or not this is a positive reflection of the emphasis on alcoholism this country has extended since the 1970 enactment of Public Law 91–616. You may not be aware, Mr. Chairman, but cirrhosis mortality figures are one of the basic numbers used in the Jellinek formula which measures the incidence of alcoholism in various nations. It is not inconceivable that this reduction in cirrhosis may indicate the early signs of a reduction in alcoholism.

As a scientific, however, I must caution that this may be nothing more than a simple aberration of statistical observation; but with the therapeutic nihilism and negative attitudes toward alcoholic people in this country which have persisted for far too long, it is important to share a hopeful sign.

There are others: Preliminary statistics on highway fatalities in 1974 indicate a reduction in fatalities of almost better than 19 percent, or 10,000 fewer people being killed on the highways in 1974 as contrasted to 1973. It is true that the popular rationale for this is ascribed to the nationwide reduction of speed limits to 55 miles per hour; but we cannot, in all fairness, lose sight of the fact that severe alcohol problems have been a major contribution to 40 percent of all

traffic fatalities in this Nation. And during this same interval we are measuring, the highway traffic safety programs were being fully implemented, implied consent laws were being passed, driving while intoxicated laws were being enforced, and treatment for offenders was being implemented.

But there is more: A study of alcoholism treatment facility outcome measures is nearing completion for distribution to the public. This study reveals that persons entering treatment at the NIAAA-supported centers are severely impaired individuals. They drink nine times more alcohol than the average individual and, as a consequence, they suffer severe consequences at a rate almost 12 times that for the nonalcoholic person. They are severely socially impaired; more than 50 percent are unemployed and more than half have broken marriages. They also have lower incomes and less education than the average person.

However, Mr. Chairman, in spite of their severely impaired statuses, clients of these centers show substantial improvement in their drinking behavior after treatment, measured at 6- and 18-month intervals following entrance into the program. Mr. Chairman, the rate of improvement for these severely ill, severely impaired individuals is 70 percent, as measured by several different outcome indicators.

In all fairness, Mr. Chairman, although this improvement rate is impressive, I must stress that only about 25 percent of these clients have abstained for at least 6 months and only 10 percent report total abstention at 18 months. But bear in mind while the majority of improved clients are drinking moderate amounts of alcohol, they are doing so at levels much, much below what could be described as alcoholic drinking. We can also see from this data that people who recover from alcoholism may pass through periods of drinking and abstaining.

Perhaps it is time, Mr. Chairman, that we, as a nation, recognize different outcome measures for success than forevermore abstinence. I believe this is necessary for developing a reasonable perspective about what constitutes success in the treatment of alcoholism.

We might further break down the 70-percent recovery rate by saying that of the people who have recovered in these treatment programs, one-third abstain totally, one-third are periodic drinkers, and one-third drink within the elements of normal drinking. These findings should not be interpreted by anyone as a suggestion that recovered alcoholic people should try to become social drinkers. It merely suggests that unrealistic criteria can guarantee an appearance of failure, when, in fact, failure does not exist. Some will attack our publicly sharing these findings. We cannot assume, I believe, a paternalistic mode of hiding from the public's right to know scientific facts which attack conventional wisdom and mythology.

There is more. Although there is no guarantee in alcoholism recovery as to who will relapse and who will not, a finding in this study reveals that relapse rates for those who go back to normal drinking in the recovery period are no higher than for those who are long-term abstainers. Stated another way, the evidence suggests that for some recovered alcoholic people, moderate drinking does not guarantee a certainty of full relapse.

As a scientist and as a physician, I must share one other major finding with you: Recovery rates do not seem to be correlated to any

single treatment method, neither in locale such as hospitals, halfway houses, or outpatient care, nor to specific treatment techniques such as group counseling, individual therapy, anti-abuse therapy, or Alcoholics Anonymous. It would appear, then, that the fact of treatment is more important than the type of treatment the individual receives. The only exception to this finding is that treatment given in sufficient amounts and intensity produce greater positive outcomes.

What we are saying, Mr. Chairman, and what we are finding, is that the ability to receive treatment, irrespective of the locale or technique, guarantees high success rates in the treatment of alcoholic people of this Nation. Alcoholic people are very treatable.

There is other positive evidence that I would share with this committee. Alcoholics Anonymous reports that its membership rolls increased from 500,000 members in 1970 to a membership of more than 750,000 members in 1974, which AA generously attributes to the adoption of Public Law 91-616 and the creation of NIAAA and its programs. The second statistic I would share with you is that since the passage of the alcoholism legislation, each of the 50 States has created statewide alcoholism programs with formula grant moneys.

Am I suggesting, Mr. Chairman, that we need not do anything more about alcoholism since we have had such a record of success? My rhetorical question demands a strong response of no. I might add as an aside that the appointment of my esteemed colleague, Dr. Ernest Noble of California, as my successor is not only flattering to me personally but also an indication of the fact that the scientific community considers this an area of important endeavor and such a highly qualified man accepting this appointment as my successor is proof of that commitment.

However, we cannot wipe out 200 years of neglect with just a few years of national attention to this important issue. National attention, by the way, that came at a time in Federal history when budgets were tight and personnel resources were limited.

I call to your attention, for example, the chart attached to my statement that shows the personnel allocations of resources for the various institutes of health of the Department and the comparison of how few NIAAA has. But we were always promised more.

And also, Mr. Chairman, I might point out, since we share another mutual interest, that the National Institute of Environment and Health Sciences is similarly deprived, as is the Alcoholism Institute. I did not recognize it until I was preparing this testimony.

On March 18 of 1971, during oversight hearings, Dr. Vernon Wilson, then the head of the Health Services and Mental Health Administration, provided the Special Subcommittee on Alcoholism and Narcotics of the Senate Labor and Public Welfare Committee a professional judgment budget. That budget stated that the Federal alcoholism program would require for its multiple programmatic responsibilities for this Nation a 5-year budget of $2.1 billion.

I need not remind this committee that although, in difficult fiscal times, we have done reasonably well, we have not come close to what the resources require to deal effectively with this enormous problem.

There are other sadnesses besides the lack of personnel for the Institute and the inadequate budgetary outlays. Operating in our alcoholism programs which we support we find what I call the "Inverse

Pyramid", where the "haves" get most of the resources and the "have-nots"—the patients—get the least. In other words, close to one-half of the expenditures in these programs are for indirect costs with less than one-half available for direct patient care. There must be an attempt to right that pyramid so that fewer resources are expended on behalf of the people at the top of the hierarchy and more is dispersed to the people the programs are designed to serve.

I think also this committee ought to reconsider the conventional wisdom of having always a separate program for other drugs and always a separate program for the drug alcohol. I am now convinced that the time has come to question the advisability of this total separation and duplication. They appear to be a product of mythology, convention, and territoriality rather than based on reality. I know, Mr. Chairman, I step on some delicate territorial toes when I take this stand, but delicacy is not one of my strengths; I can only count on my dedication to these suffering people and to the limited resources a society can expend.

I would suggest to this committee, furthermore, that they look more closely at the bureaucratic mechanisms of diverting congressional intent. I do not, Mr. Chairman, wish to jump upon the bandwagon of attacking my former fellow bureaucrats because it is fashionable today to do so. In the main, they are a hard-working, well-intentioned lot. But I am aware, unfortunately, or how programmatic thrusts were blunted, for example, by the public affairs section of the Department arbitrarily insisting we delete articles about alcohol and poor people because they thought it would tarnish HEW's image; or where this same group would impose their judgment that they thought an article was too sophisticated for the public, whereas our tests and our programmatic experience had revealed that the articles had manifested the greatest of interest.

I would also respectfully suggest that the Congress examine whether or not it is contributing to a lessening of its own intent in enacting legislation through the mechanism of the writing of regulations. In my opinion, Congress cannot continue to write laws and have these laws literally rewritten and redirected by bureaucratic regulation setting.

It is my recommendation that Congress begin to consider methods whereby legislation which requires the writing of regulations have written into the law setting a date for regulations hearings before the originating congressional committee, to take testimony which will measure whether or not draft regulations in fact manifest the intent of Congress.

The Congress of the United States, in my opinion, if it wishes to more fully realize its own programs for the people of this country, must set mechanisms of accountability and review which will preclude subversion of this intent by the bureaucratic processes.

I must raise for your consideration one last important issue. One of my proudest developments in Government was that the NIAAA not only talked about prevention, it set up operational mechanisms to achieve that important goal. No matter, Mr. Chairman, how much money is spent, no matter how successful treatment programs are, until programs are developed which are in the direction of preven-

tion and the promotion of health, we will always be dissatisfied with our programs and the expenditure of taxpayers' dollars.

But all of us have a problem in this area around the issue of prevention. Prevention programs require different types of perspective and special kinds of programs. As a physician, you know that I have been referred to as a health care provider. But let me risk incurring the wrath of my fellow physicians by stating that I was trained in the economics of sickness care, not health care, and I apologize to your esteemed Dr. Carter with whom we share, I hope, mutual respect about that.

My expertise in sickness care does not automatically give me the wherewithal for the economics of health care. The same is true in programs for prevention of alcoholism. Those who are brilliant and successful in the art of treating the casualties of alcoholism have no special skills to contribute in the development of prevention programs. As a matter of fact, they may retard prevention program growth because of the territoriality which develops when a program is successful, visible, and funded. The natural tendency is to want to keep so-called interlopers out of their field of endeavor.

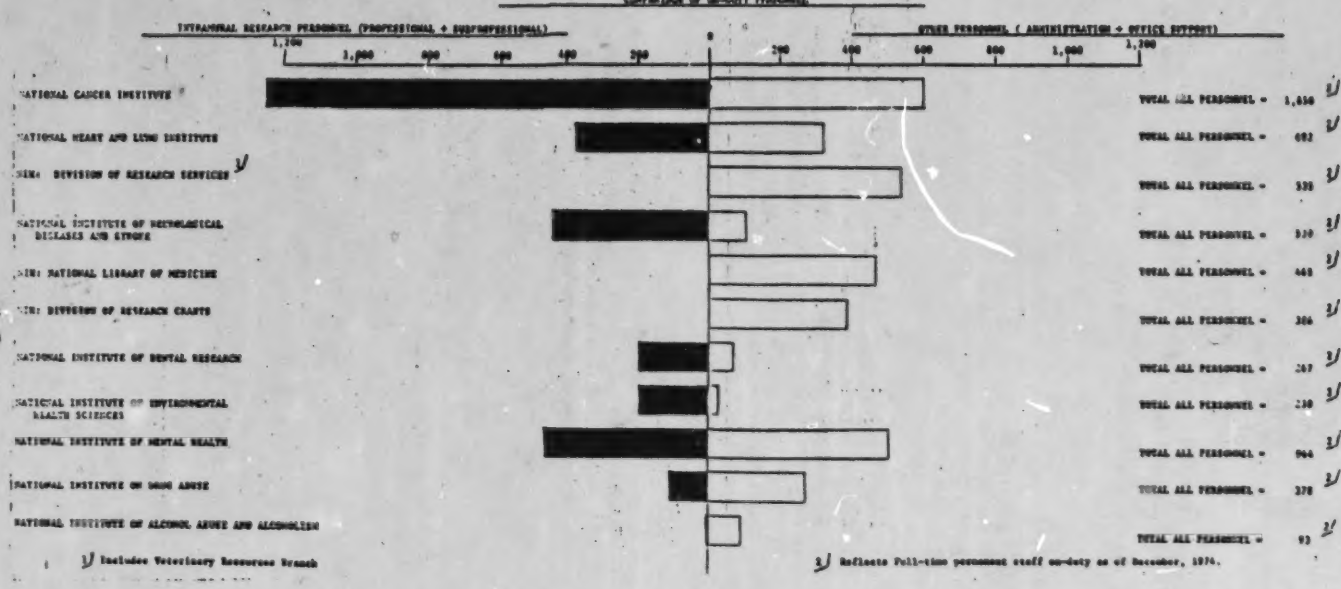
This is already going on in the alcoholism field today and therefore, Mr. Chairman, I strongly recommend that in the renewal legislation under your consideration, which I strongly support, an earmarked authorization for prevention programs in alcoholism of not less than $20 million per year be included in whatever authorization you consider.

Without earmarking for prevention, without the imprimatur of congressional intent, we will see a tendency toward just doing more and more of more of the same instead of creating innovative prevention approaches, and we will come together at a future hearing frustrated instead of fulfilled.

Mr. Chairman, there is a great deal more in both general and specific terms that I could share with this committee. I would prefer, however, that that come out as an expression of interest manifested by questions of this committee rather than in my statement. I again thank you for your generosity for inviting me to testify before this committee and I will be happy to answer any questions you may have.

[Testimony resumes on p. 49.]

[The chart and the letter with attachment, referred to, follows:]


COMPARISON OF ON-DUTY PERSONNEL
INTRAMURAL RESEARCH PERSONNEL (PROFESSIONAL + SUBPROFESSIONAL)
OTHER PERSONNEL (ADMINISTRATION + OFFICE SUPPORT)
1,200
1,000
800
600
400
200
0
200
400
600
800
1,000
1,200
NATIONAL CANCER INSTITUTE
NATIONAL HEART AND LUNG INSTITUTE
DRR: DIVISION OF RESEARCH SERVICES 1/
NATIONAL INSTITUTE OF NEUROLOGICAL DISEASES AND STROKE
NLM: NATIONAL LIBRARY OF MEDICINE
DRG: DIVISION OF RESEARCH GRANTS
NATIONAL INSTITUTE OF DENTAL RESEARCH
NATIONAL INSTITUTE OF ENVIRONMENTAL HEALTH SCIENCES
NATIONAL INSTITUTE OF MENTAL HEALTH
NATIONAL INSTITUTE ON DRUG ABUSE
NATIONAL INSTITUTE OF ALCOHOL ABUSE AND ALCOHOLISM
TOTAL ALL PERSONNEL = 1,656 2/
TOTAL ALL PERSONNEL = 692 2/
TOTAL ALL PERSONNEL = 535 2/
TOTAL ALL PERSONNEL = 520 2/
TOTAL ALL PERSONNEL = 468 2/
TOTAL ALL PERSONNEL = 306 2/
TOTAL ALL PERSONNEL = 267 2/
TOTAL ALL PERSONNEL = 230 2/
TOTAL ALL PERSONNEL = 964 2/
TOTAL ALL PERSONNEL = 378 2/
TOTAL ALL PERSONNEL = 93 2/

1/ Includes Veterinary Resources Branch

2/ Reflects full-time permanent staff on-duty as of December, 1976.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
ROCKVILLE, MARYLAND 20852

NATIONAL INSTITUTE
ON
ALCOHOL ABUSE AND ALCOHOLISM

August 29, 1975

Honorable David Mathews
Secretary of Health, Education, and Welfare
Washington, D. C. 20201

Dear Mr. Secretary:

Pursuant to our discussion, I am forwarding the attached briefing report, "National Institute on Alcohol Abuse and Alcoholism: 1970-1975 -- Progress, Needs and Challenges." It highlights the accomplishments of the Institute during the years I have been privileged to serve as Director. It also summarizes my thoughts on the outstanding issues that face the Institute and the Nation in coming to grips with the problem of alcohol abuse and alcoholism.

In submitting this final report, I wish to reiterate my appreciation to the Congress, the President, the Department, the Institute staff, the alcoholism field, and the American people for their support of the Federal alcoholism effort in building this record of accomplishment.

Sincerely yours,

Morris E. Chafetz, M.D.
Director

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM: 1970-1975

Progress, Needs and Challenges

Report to

The Secretary of Health, Education, and Welfare

from the

Director of the National Institute on Alcohol Abuse and Alcoholism

Alcohol, Drug Abuse and Mental Health Administration
Public Health Service
Department of Health, Education, and Welfare

August 29, 1975

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I. INTRODUCTION AND CHRONOLOGY

Beyond the obvious role of the Federal government in translating public moral judgment about alcohol and alcoholism into law during the past two hundred years, the history of active Federal involvement in alcoholism treatment and rehabilitation has been a short one indeed. As late as 1965, there was but one identifiable alcoholism specialist among the entire staff of the National Institute of Mental Health. In 1967, HEW Secretary John Gardner established a small National Center for the Prevention and Control of Alcoholism within NIMH, but its budget of less than three million dollars was a pitifully insignificant sum to combat an illness which afflicted millions of Americans. By late 1970, the Center had been upgraded to Division status within NIMH and alcoholism appropriations for Fiscal Year 1971 had been set at $14 million. However, it remained for new landmark legislation at the end of 1970 to initiate a new era of significant Federal leadership and commitment to the problems of alcohol abuse and alcoholism.

EVENTS AND MILESTONES IN THE FEDERAL ALCOHOLISM EFFORT

DECEMBER 1970--After unanimous Congressional passage, President Nixon signs into law the "Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970," creating the National Institute on Alcohol Abuse and Alcoholism and authorizing project grants, contracts, and State formula grants for the provision of prevention, treatment, and rehabilitation services.

MAY 1971--The National Institute on Alcohol Abuse and Alcoholism (NIAAA) becomes operational within the National Institute of Mental Health, an agency of HEW's Health Services and Mental Health Administration, with Dr. Morris E. Chafetz as its first director.

JUNE 1971--The First Annual Alcoholism Conference of the National Institute on Alcohol Abuse and Alcoholism is held in Washington, D.C. with 300 attendees.

JUNE 1971--The NIAAA Fiscal Year 1972 budget appropriation of $84.6 million represents a six-fold increase in NIAAA appropriations over the previous year, and a twenty-eight-fold increase over the previous five years.

AUGUST 1971--The National Conference of Commissioners on Uniform State Laws passes the "Uniform Alcoholism and Intoxication Treatment Act," which is designed to remove public drunkenness from the criminal justice system.

FEBRUARY 1972--The Secretary of Health, Education, and Welfare submits the First Special Report to the U.S. Congress on Alcohol and Health.

FEBRUARY 1972--The NIAAA launches its nationwide public service education campaign through the mass media, with mailings to over 12,000 radio, television and print outlets.

JUNE 1972--All 50 states qualify a comprehensive alcoholism program for a proportionate share of $30 million in State formula grants.

JUNE 1972--The NIAAA public service education campaign penetrates into all 50 States and several foreign countries.

JUNE 1972--The NIAAA completes its first full year of operation with a total of 500 grants in the areas of research, training, State assistance, and community assistance, representing $81.5 million in funding.

JULY 1972--The National Clearinghouse for Alcohol Information begins operations, responding to public inquiries generated by the education campaign and providing a central repository of information services in the areas of alcohol, alcohol abuse, and alcoholism for the health professions and the lay public.

SEPTEMBER 1972--The NIAAA Division of Prevention, the first such division in any Federal health agency, is activated.

OCTOBER 1972--The NIAAA education campaign wins First Prize, Public Service Advertising Campaign, at the New York International Film Festival.

APRIL 1973--The final report of the National Commission on Marihuana and Drug Abuse confirms the NIAAA Alcohol and Health Task Force report finding that alcohol is the most abused drug in the United States.

MAY 1973--The NIAAA is placed within the National Institutes of Health.

JUNE 1973--The Alaskan Native mini-grant program is launched, funding for the first time alternatives to alcohol in remote Alaskan villages according to needs determined by the individual communities.

JUNE 1973--Follow-up evaluation of the first phase of the NIAAA public service education campaign indicates 59% of the American public now view alcohol as a drug.

JUNE 1973--The National Clearinghouse for Alcohol Information completes its first year of operation, having responded to more than 900,000 information requests.

JUNE 1973--NIAAA's Third Annual Alcoholism Conference attracts over 1,400 participants to Washington, D.C., nearly a five-fold increase over 1971.

JULY 1973--The National Center for Alcohol Education begins operations developing education and training programs as part of an expanding Institute prevention effort.

JULY 1973--The Institute announces a comprehensive, formalized plan to stimulate third-party payments for alcoholism treatment services, including objectives for program accreditation, personnel certification, management and financial management training, development of a model insurance benefits package and a model program cost accounting system, and initiation of incentive contracts for the provision of alcoholism treatment on a profit-making basis.

SEPTEMBER 1973--NIAAA is established as a separate Institute within the newly formed Alcohol, Drug Abuse, and Mental Health Administration, along with the National Institute on Drug Abuse and the National Institute of Mental Health.

NOVEMBER 1973--NIAAA releases figures that indicate over 400 Institute-supported treatment programs handle 140,000 clients annually, including a doubling of the caseload at NIAAA-funded comprehensive Alcoholism Treatment Centers over the previous 12 months.

DECEMBER 1973--With the release of impounded funds, NIAAA appropriations exceed $218 million for Fiscal Year 1974.

DECEMBER 1973--A national alcohol education task force of the Education Commission of the States is created, with South Carolina Governor John West as Chairman, to generate better approaches to alcoholism prevention.

MAY 1974--President Nixon signs into law the "Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974."

JUNE 1974--NIAAA's Fourth Annual Alcoholism Conference attracts over 4,000 participants, an increase of nearly three-fold over the previous year and nearly 14 times the attendance of the first conference held three years earlier.

JULY 1974--The Second Special Report on Alcohol and Health is sent to Congress and released to the American public, presenting a comprehensive look at new knowledge in the alcohol abuse and alcoholism fields.

JULY 1974--The NIAAA initiates four regional Area Alcohol Education and Training Programs in a move to decentralize its training and education activities.

AUGUST 1974--The first two incentive contracts are awarded to demonstrate the feasibility of providing self-sustaining alcoholism treatment services through the third party payment system.

SEPTEMBER 1974--Provisions for alcohol abuse education, treatment and prevention are included in the Juvenile Justice and Delinquency Act signed into law by President Ford.

SEPTEMBER 1974--President Ford signs into law the Alcohol and Drug Abuse Education Act.

DECEMBER 1974--NIAAA is appropriated $146 million for Fiscal Year 1975.

MARCH 1975--Results of the first large-scale follow-up study of clients treated by Institute-funded Alcoholism Treatment Centers indicate 70% recovery rates 18 months after intake.

MARCH 1975--The first 42 alcoholism programs are accredited by the Joint Commission on Accreditation of Hospitals under newly adopted national standards.

APRIL 1975--National Standards for the certification of alcoholism counselors, developed under NIAAA sponsorship by the alcoholism field, are promulgated.

MAY 1975--The Institute assigns high program priorities to eight areas of strong concern: Spanish-Americans, Blacks, the aged, youth, women, Indians, occupational alcoholism, and public safety.

JUNE 1975--Dr. Morris E. Chafetz resigns as Director of the National Institute on Alcohol Abuse and Alcoholism effective September 1, 1975, after five years as the head of the Federal alcoholism program.

II. LEGISLATION

The period from 1970 to 1975 was marked by important progress in the enactment of legislation advancing the alcoholism movement. For the first time the Federal thrust was provided with a strong Congressional mandate to reduce the prevalence of alcohol-related problems in the Nation, and the Department of Health, Education, and Welfare was given the tools and resources to begin that task. The advancement of the welfare of alcoholic people and their basic human right to humane treatment found growing force in Federal law.

- PL 91-211, the Community Mental Health Amendments of 1970, took effect on July 1, 1970. The legislation amended and strengthened authorities for alcohol abuse and alcoholism programs by authorizing direct grants for special projects outside of community mental health centers. Subsequent appropriations, however, were insufficient to implement the Act.

- On December 31, 1970 President Nixon signs into law landmark legislation in the field of alcoholism -- the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act (PL91-616), which was passed unanimously by both Houses of Congress. Passage of this Act marked the start of large-scale action in the alcoholism field by the Federal government.

  Major Provisions

  - Establishment of the National Institute on Alcohol Abuse and Alcoholism;

  - Establishment of a National Advisory Council on Alcohol Abuse and Alcoholism to make recommendations to the Secretary of Health, Education, and Welfare on policy relating to the Federal alcoholism program, and to review grant awards in this area;

  - Authorization of formula grants to the States, and project grants to organizations and institutions;

  - A requirement that comprehensive State health plans under section 314(d) of the Public Health Service Act include services for the prevention and treatment of alcohol abuse and alcoholism commensurate with the extent of these problems within the State;

  - Prohibition of discrimination by hospitals receiving aid under this Act in regard to admitting alcoholic people for treatment.

- The Uniform Alcoholism and Intoxication Treatment Act decriminalizing alcoholism and public drunkenness was drafted and approved by the National Conference of Commissioners on Uniform State Laws at its August 1971 annual meeting. Then-HEW Secretary Elliot L. Richardson wrote to all 50 State governors urging enactment. The Uniform Act has since been adopted, all or in part, by at least 27 states, although not all of these States have decriminalized public intoxication.

Major Provisions and Recommendations

- A declaration of State policy that "alcoholics and intoxicated persons may not be subjected to criminal prosecution because of their consumption of alcoholic beverages but rather should be afforded a continuum of treatment in order that they may lead normal lives as productive members of society."

- Organization of a division of alcoholism within the State government.

- Outline of standards for alcoholism and intoxication treatment, including --

  (A) A patient shall, if possible, be treated on a voluntary rather than an involuntary basis.

  (B) A patient shall be initially assigned or transferred to outpatient or intermediate treatment, unless he is found to require inpatient treatment.

  (C) A person shall not be denied treatment solely because he has withdrawn from treatment against medical advice on a prior occasion or because he has relapsed after earlier treatment.

  (D) An individualized treatment plan shall be prepared and maintained on a current basis for each patient.

  (E) Provision shall be made for a continuum of coordinated treatment services, so that a person who leaves a facility or a form of treatment will have available and utilize other appropriate treatment.

- On May 14, 1974 the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments (PL93-282) became law. The Act extended the grant authorities of the Institute for another two years, consolidated all Institute program authorities under one Act, and increased authorization levels for NIAAA program funding. The Act also provided for strengthened legislative insurance and encouragement of treatment for alcoholic people.

Major Provisions

- The establishment of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), to include the National Institute on Alcohol Abuse and Alcoholism as a separate entity co-equal with the National Institute on Drug Abuse and the National Institute of Mental Health.

- Authorization of project grants and contracts for prevention and treatment of alcohol abuse and alcoholism, including demonstration, service, evaluation, education and training projects, and programs

and services in cooperation with schools, courts, penal institutions, and other public agencies;

- A ban against hospitals receiving any Federal aid if they discriminate against alcoholic persons, either in admission or treatment policies;

- Provision for confidentiality of records of any client involved in any alcoholism program receiving Federal assistance, except upon their written consent for disclosure, or in the case of a bona fide medical emergency, anonymous scientific research, or court order;

- Authorization of an Interagency Committee to evaluate the adequacy and technical soundness of all Federal programs related to alcoholism, and to coordinate all Federal efforts in this area;

- Authorization of special grants to States implementing the Uniform Alcoholism and Intoxication Treatment Act (the first such time Congress has made a formal endorsement of a Uniform Act for implementation by the States).

NEEDS AND CHALLENGES: LEGISLATION

- Many States which have passed the Uniform Act have adopted it only in part, and among the States which have adopted the Act, there is typically a wide gap between the treatment services specified by law and the treatment services actually available. Funds have been awarded to 16 States which had in effect the basic provisions of the Uniform Act as of June 30, 1975.

- The anti-discrimination provision of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974 has not been enforced.

III. TREATMENT

Since its inception, the first and highest priority of the Institute has been to make effective, quality treatment available to every alcoholic person in the United States. We have worked to realize our primary goal by supporting the development of comprehensive alcoholism treatment programs at State and community levels. It has been the position of the Institute that the individual States and communities of the Nation have the best ability to recognize specific local needs within their respective geographic regions and design their alcoholism programs accordingly. Because the complexity of the problem defies simplistic solutions, it would have been a grave mistake to attempt to advocate one single program model for the entire alcoholic population of the country. Rather than trying to develop set programs into which we place people -- the all-too-common approach that has proved so disastrous for alcoholic clients in the past -- our objective has been to foster the development of programs which respond effectively to individual needs and differences.

In this context, the Institute also has urged the integration of alcoholism treatment programs within the entire range of community health and social services, so that our programs could meet the full spectrum of needs that contribute to the hurt of a human being. Fragmentation of services not only reduces the availability and effectiveness of treatment programs, it also keeps the alcoholism problem hidden from public view. Until we reach the point where alcoholism victims can avail themselves of all the human services and treatment accorded the victims of most other illnesses, we will not be able to significantly reduce the alcoholism problems of the Nation.

- Since the inception of the Institute a nationwide treatment program has been put into place, with more than 600 community alcoholism programs placed into operation.

- Five years ago only a handful of States had viable alcoholism programs. In FY 72 the Federal formula grant program was initiated and it made up to $30 million available to States which developed acceptable comprehensive alcoholism program plans. During the course of FY 72 all States developed qualifying plans. Ongoing alcoholism programs have since become operational in all 50 States, the District of Columbia, Puerto Rico, Virgin Islands, Guam, and the Trust Territories of the Pacific, with many States significantly increasing commitments of their own funds for the provision of alcoholism services. In addition to the designation of a single responsible agency and an advisory council in each State, most States have operational county or regional councils. The appropriation for Federal formula grants to the States in FY 75 was $52 million.

Special Projects

A significant strength in the service building effort has been the use of the categorical funding approach to meet the wide-ranging, individualized needs of special population groups. Many population groups have been afforded

services for the first time in a number of communities -- the poor, American Indians, Blacks, Spanish-Americans, Alaskan Natives, women, youth, and migrant farm laborers. Special guidelines have been developed by the Institute for these targeted populations to assist them in developing effective programs. Because of the specialized needs of these groups, the knowledge base of the alcoholism field has been broadened. The Institute has stood as a Federal advocate for these groups, and in a number of instances -- among Blacks, Spanish-Americans and American Indians -- it has helped foster the development of national constituency organizations.

- At the present time, the Institute supports 147 programs for Indian people in response to applications originated by Indians for programs run by Indians representing an investment of $16.6 million for FY 75.

According to the First Alcohol and Health Report, "Among American Indians, the incidence of alcoholism is at an epidemic level. The rate is estimated to be at least two times the national average. On some American Indian reservations, the rate of alcoholism is as high as 25 to 50 percent." Until the creation of the Institute and the initial allocation of $750,000 for American Indian programs, Native American people had to rely exclusively on limited OEO funds for alcoholism treatment. The initial request for proposals generated a $7 million demand with only one-tenth of that sum available. A technical review group composed of Indians was established as part of the peer group review process that has been traditional to the Institute. This program has expanded rapidly with evaluation indicating a significant positive impact on this major problem of Indian people. A study of Northwest programs involving several major tribal groups has indicated up to 46% recovery rates over an 18-month follow-up period. One program funded to the student council of an Indian boarding school became the prototype for seven other student-oriented school programs, both Indian and white.

- In response to the pandemic problem of alcohol abuse and alcoholism among the Alaskan Native population, during FY 73 and 74 the Institute funded 173 special mini-grants up to $10,000 for an approximate total of $173,000. These one-year project grants assisted Alaskan Native communities in developing their own alternatives to alcohol abuse. The overwhelming response was to construct, remodel, or rent village centers in which to engage in such constructive activities as arts and crafts, youth and adult recreation, repair and sale of small machinery, employment training, village gatherings and A.A meetings. Preliminary reports indicate a significant reduction in alcohol-related problems. The mini-grant program was developed in collaboration with State and local alcoholism agencies and organizations as the first step in an overall Alaskan Native alcoholism program. Liaison has been established to integrate this effort with related Federal, State and local health and social service planning. In addition, as part of a $1.5 million grant to the National Council on Alcoholism (Alaska) for public information and education programs, the Alaskan Native Commission on Alcohol and Drug Abuse is designing, producing, translating and distributing multi-media educational materials for both rural and urban Alaskan Native populations.

Occupational Alcoholism Programs

Individuals with alcohol-related problems have traditionally not been identified until their behavior has come to the attention of law enforcement or various social agencies -- typically in the chronic phase of alcoholism. Job impairment related to excessive alcohol use is observable at a far earlier stage of this progressive illness. As a result, occupational programs were stimulated as early as 1946. However, even by 1970 such programs were limited both in number and effectiveness. As occupational programs comprise one of the few secondary prevention opportunities, their expansion and improvement were among the initial priorities of the Institute.

The Institute's principal emphasis in the occupational area has been providing the individual States with the capability of rendering technical assistance to foster program development in both the public and private sectors. Although this effort has been relatively inexpensive it has resulted in at least a ten-fold increase in programs adopted by business to reach out and assist employees with alcohol-related problems. As is the case with other highly treatable illnesses, this form of early outreach has demonstrated significant success: Recovery rates, without job loss, of over 80% are now being reported. Moreover, occupational programs have proven to be highly cost-effective, and with alcohol-related problems currently costing the Nation's economy more than $25 Lillion annually (including $9.37 billion in direct losses to business and industry), both management and labor are devoting increased attention to this type of programming.

- More than 100 Institute-trained occupational program consultants are presently employed in all 50 States, promoting and assisting in the development of State and local programs.

- More than 275 new occupational alcoholism programs have been established and currently serve a work force of approximately 2,750,000 persons.

- Significant partnerships have been developed with the Civil Service Commission and the Department of Defense to foster Congressionally mandated occupational programs for Federal employees with alcohol-related problems.

Joint Alcohol-Drug Abuse Activities

A selected number of joint alcohol-drug abuse service programs have been developed with the National Institute on Drug Abuse as a demonstration-research effort to examine the implications of such programming for the client, the administrator, funding sources, and constituencies. There is increasing community interest in developing such joint programs, and these research projects are designed to provide both the alcoholism and drug abuse fields with the salient issues and considerations that should be recognized in planning and implementing future joint efforts.

Treatment Alternatives to the Criminal Justice System

According to the First Alcohol and Health Report, "Public intoxication alone accounts for one-third of all arrests reported annually. If such alcohol-related offenses as driving while under the influence of alcohol,

disorderly conduct, and vagrancy are considered, the proportion would rise to between 40 and 49 percent." Alcohol problems cost the criminal justice system an estimated $500 million annually. Of the four index crimes of violence, an association with alcohol has been recorded in 41% of all assaults, 34% of all forcible rapes, 64% of all murders, and a significant percentage of all robberies.

The Institute has fostered a number of program efforts which have brought a service-rehabilitation focus into the law enforcement process and turned the attitudes of police officers, judges and probation officers toward viewing alcoholism as an illness requiring treatment instead of as a behavior that can only be dealt with in a harsh, punitive, and non-rewarding manner within the criminal justice system.

- The Institute has supported the development of treatment service components in conjunction with the Alcohol Safety Action Program (ASAP) of the Department of Transportation at approximately 25 sites. Because a high proportion of drinking driver offenders are heavy, problem drinkers, these programs are designed to capitalize on the ASAP case-finding potential by providing treatment to clients referred by judicial authority.

- Institute-supported public inebriate programs are providing treatment alternatives to the revolving-door judicial system of dealing with public drunkenness cases.

- The Institute has also supported a criminal offender program in a State prison environment, where as many as 50% of all felons have alcohol problems. In contrast to the high recidivism rates that characterize the general prison population nationally, the recividism rate among inmate clients of this program during its three-year experience has been a mere 4%.

Health Insurance

Traditionally the provision of benefits under third party payment plans, to include private sector health insurance, has been denied for the treatment of alcoholism either by outright exclusion or highly restrictive limitations. At best coverage has been allowed only in high cost treatment settings such as general hospitals where treatment for the primary diagnosis of alcoholism has for the most part been unavailable. As a result, such abuses as subterfuge diagnoses or outright refusal of admission have been the rule. The American Hospital Association reported in 1972 that less than half the Nation's hospitals would accept patients with a primary diagnosis of alcoholism.

Recognizing this inequity, and recognizing as well the need to integrate the payment of treatment for alcoholism into the traditional health payment system, the Institute in FY 74 created an objective designed to overcome the various barriers to third party payments. Accomplishing this overall objective required the development and institution of a number of controls and standards to assure carriers that they would be supporting quality care in accountable facilities:

- Acceptance of program standards developed and promulgated under Institute sponsorship by the Joint Commission on Accreditation of Hospitals allowing for formal accreditation by this body;

- Derivation of certification standards related to the position of alcoholism counselor in treatment program settings;

- Policy development in alcoholism services related to Health Maintenance Organizations;

- Fiscal management training for Federally funded programs;

- Development of actuarial studies by the major carrier associations;

- Consultation to public and private health insurance sectors in the development of broad-based alcoholism benefits;

- An incentive contract program established to stimulate demand for the coverage of alcoholism treatment in social residential and outpatient settings apart from the general hospital.

This objective has begun to have positive impact as some carriers are becoming more sensitive to the needs of alcoholic people for health care services. More carriers are including alcoholism as a basic coverage in their policies. In addition, an increasing number of States have enacted legislative mandates for alcoholism coverage.

TREATMENT: NEEDS AND CHALLENGES

- Despite the important progress that has been made in the alcoholism treatment area over the past five years, the largest number of professionals and service agencies of all kinds still do not treat alcoholism.

- Although a specific capacity for alcoholism treatment has been developed, the integration and general availability of services within the larger context of the total health care delivery system is still a long way from reality.

- A high priority of the Institute has been the development of meaningful service programs for specific minority groups, and the involvement of minority persons in the planning, development, and implementation of such programs. As other priority areas emerge in the alcoholism field, it will be vital that the interest and commitment in this program area not diminish, but rather be strengthened and expanded. While programs for American Indians and Alaskan Natives have been highly successful, programs for Blacks and Spanish-Americans need much greater development.

- As impetus builds for more joint alcohol-drug abuse programs, careful attention needs to be paid to respecting the individual differences and constituencies connected with these programs, so that client needs are not lost in an impersonal, omnibus service delivery system. Care must also be taken so that, in any amalgamation of alcohol and drug programs, alcohol does not wind up playing second fiddle once more.

III-6

- Despite strong progress in the development of program standards, alcoholism remains a relatively limited benefit under the vast majority of health insurance programs.

- As insurance coverage for alcoholism continues to become more and more common, the effort must be made to assure that the acceptance of such coverage is appropriately reflected in any National Health Insurance plan.

- The Institute must take an increasingly active role in bringing NIAAA-funded programs into position for accreditation.

- Community service programs need to devote increasing attention and effort to obtaining financial self-sufficiency through third party payments, including both public and private insurance benefits.

IV. PREVENTION AND INFORMATION

While the first priority of the Institute has been the establishment of quality alcoholism treatment services, we have also recognized that no illness in the history of man has been eradicated by just treating the casualties. Prevention through public education is considered a key method of reducing alcohol problems in the United States. Accordingly, the Institute has sought to mobilize education programs directed to the Nation's youth, who represent a major segment of the population, and to their parents, from whom the basic attitudes and lifestyle practices so important to the prevention of alcohol abuse are first learned and developed.

- In September 1972 the NIAAA Division of Prevention, the first such division in any Federal health agency, was established to develop, implement, and evaluate National policies and programs aimed at the prevention and control of alcohol abuse and alcoholism in the United States. Through its Youth Education Branch, Community Prevention Branch, and the National Clearinghouse for Alcohol Information, the Division has directed its resources toward modifying the attitudes and behavior of a heterogeneous society in which more than 100 million Americans use alcoholic beverages.

Grants and contracts have been awarded to develop pilot projects relevant to meeting the needs of young people in a variety of settings. Innovative approaches have included a National YMCA Alcohol Education Project to develop a model program designed for students in grades 4 to 6; a "peer group" demonstration project utilizing older students to work with younger students in an inner city area; a model learning system in alcohol abuse and alcoholism prevention for grades kindergarten through 12; and a study to assess the kinds of alcohol-related curriculum materials currently available and the kinds of training received by classroom teachers.

Community prevention programs are directed toward the adult population who drink and may become alcohol abusers. Established organizations, recognized for their contributions to the welfare of their respective communities, have been called upon to assist in the prevention of alcohol abuse and alcoholism. The Institute is collaborating with community leaders who have daily contact with people encountering alcohol problems, such as clergy, physicians, and nurses, group health associations, and others. Efforts also are being directed toward modifying educational attitudes, behavior, destructive habits, values and feelings about alcohol. Grants and contracts in this area have included a U.S. Jaycees nationwide citizens' awareness program; a project to assess the level of awareness, understanding and needs of small business for alcohol abuse and alcoholism prevention programs; a task force of the Education Commission of the States utilizing volunteer citizen groups to bring about practical, effective resolution of alcohol abuse and alcoholism problems through education.

In framing an approach to prevention, the Institute has recognized that a number of societies which use alcohol suffer few problems as a result. These diverse societies share many common characteristics in their cultural drinking practices. The Institute has sought to develop a new National consensus of

what constitutes responsible attitudes concerning drinking which incorporates a number of these characteristics and is based upon the following principles:

1. The decision to drink or not to drink should be a personal, private decision. However, anyone choosing to drink has a responsibility not to destroy his own dignity or that of society. This in its broadest sense is a responsible attitude toward the use of beverage alcohol.

2. Those people who do drink should respect the decision of other individuals to abstain. We forget all too often that 32 percent of the adult population in this country choose not to drink, and the enormous pressure brought to bear on them to take a drink is both unfair and inexcusable.

3. People who serve alcoholic beverages to customers or guests should realize their proper responsibility. The bartender who sells too many drinks to a customer who gets drunk, and the party host who pushes unwanted or "loaded" drinks on his guests are both examples of widespread, irresponsible practices which contribute heavily to an unhealthy drinking environment.

4. The general public should understand the facts concerning alcohol and its effects on the human body, and more people must come to realize that ethyl alcohol is pharmacologically a drug capable of causing euphoria, sedation, unconsciousness, and death.

5. Those who use alcoholic beverages should avoid drunkenness (which is a drug overdose) for themselves and not sanction it for others. This can be done by avoiding the use of alcohol for its own sake, as a social crutch, or as a problem-solver, and instead using alcohol as an adjunct to other activities; by making a habit of sipping drinks slowly, and consuming alcoholic beverages with food, in relaxing social circumstances; and by knowing one's limit, and not exceeding it.

6. More people must come to understand that adults are significantly responsible for the drinking habits of youth, because the examples set by adults have a great influence on the subsequent drinking attitudes and practices of young people.

7. Finally, the general public must begin to realize that the line between alcohol abuse and alcoholism cannot be clearly drawn. The difference is mostly a matter of degree and consequence, of purpose and pattern, and therefore, there is an important link between the problem of alcoholism and the irresponsible attitudes of Americans towards drinking and alcohol abuse.

- The Institute began its first large-scale, ongoing effort to raise public awareness in 1972 by initiating its mass media public service education campaign. The campaign won the New York Film Festival Award for Best Public Service Campaign two years in a row, as well as a first place award at the Cannes Film Festival. The most frequently run messages were seen

or heard by about one-fourth of the adult U.S. population, a rate that compares well with major commercial campaigns. Longitudinal studies have confirmed significant rises in awareness of alcohol-related issues.

- As part of its continuing commitment to raise public awareness by replacing the many myths surrounding drinking and drinking problems with all of the positive and negative facts as they became available, an Institute task force compiled the First Special Report to the U.S. Congress on Alcohol and Health from the Secretary of Health, Education, and Welfare (the First Alcohol and Health Report) in December 1971. The report branded alcohol the most abused drug in the United States, and gave the Nation its first comprehensive look at the current state of knowledge about alcohol. The Second Alcohol and Health Report was released in July 1974 and presented the new knowledge acquired from leads derived from the first report. Both reports have passed the test of public and scientific scrutiny. Their findings and recommendations are included as an appendix to this report.

- In order to respond to the widespread growing awareness generated by the Federal alcoholism thrust, the National Clearinghouse for Alcohol Information was created to serve as a national focal point for the collection and dissemination of a comprehensive body of knowledge on alcohol and alcoholism. During its three years of operation, the Clearinghouse has built up a library and reference system of more than 45,000 items, and has disseminated some 8.5 million information items across the Nation and throughout the world.

- To enhance and expand upon its prevention program, NIAAA established the Information Dissemination Program (IDP) within the National Clearinghouse for Alcohol Information. IDP is a concentrated, nationwide effort to carry NIAAA prevention messages to millions of Americans, seeking to enlist their aid in a massive approach to the prevention of alcohol abuse and alcoholism. To carry out this effort, IDP uses existing and new channels of communication to mobilize a broad, action-oriented, community-based constituency which can marshal its own resources for sustained alcohol-related programs. Target groups being reached in this effort include universities, civic and community groups, professional, labor and trade associations, national youth groups, and private foundations.

- Also established within the Clearinghouse is a system for the quality evaluation of the alcohol literature. Under this system, the Clearinghouse staff has been augmented by the assistance of outside experts in the evaluation of thousands of alcohol-related articles. The objective is to identify and assure wide dissemination of works of high merit, and in so doing upgrade the overall quality of the literature within the field.

- In order to decentralize prevention efforts in the alcoholism field, in September 1974 guidelines were established for a State Prevention Coordinator's Program to be implemented through the direct auspices of each single State agency. As of May 1975, 48 State Prevention Coordinator Programs had been established and are currently in some phase of implementation. While each program varies from State to State, a requirement

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of the Prevention Coordinator Program has been a two-phase training program for each Prevention Coordinator conducted by the Institute's National Center for Alcohol Education, and the development of a comprehensive State prevention plan. The plans include, but are not limited to, a needs assessment and analysis of drinking patterns in various communities within each respective State; the undertaking of public dialogue initiated at the local level by community workers; and recommendations for modification in local community environments in order to alleviate abusive use of beverage alcohol and to bring about more open factual dialogue about alcohol usage.

- To further expand prevention efforts, earlier this year an estimated 500 national voluntary, citizens and youth organizations were identified that heretofore have not directly involved themselves in alcohol-related problems. Strategies have been developed to initiate cooperative agreements and working relationships with a number of these organizations in order to develop greater public awareness and increased activity in the area of primary prevention.

NEEDS AND CHALLENGES: PREVENTION

- Although awareness of alcohol problems and drinking issues has significantly increased, fixed stereotyping and stigmatization of alcoholism victims have not clearly moderated. Indeed the alcoholism problem may be exacerbated if we are recognizing more casualties and stigmatization is not greatly changed.

- We have not yet made significant progress towards overcoming ambivalence surrounding alcohol use, and we still sanction drunkenness in the public arena.

- Primary prevention must be continually emphasized. A community must recognize alcohol abuse as a community problem and not merely an individual one. The better health of a community requires a community approach which is a response to its own drinking pattern and problems, and this approach should include a range of strategies, since no one strategy would appear to be effective in preventing alcohol abuse in a given community. The significance of strategies that modify the social environment must be acknowledged as important in the development of a more comprehensive approach to preventing alcohol abuse.

- Because attitudes toward drinking and later behavior begin to develop at an early age, prevention efforts must reach our youth. It is critical that our efforts to reach young people enlist the entire social complex in which they live and learn. Our goal must be a community-wide approach in which realistic, healthy attitudes towards the subject of alcohol are encouraged.

- Specific efforts will be made to coordinate the prevention and education activities targeted toward youth engaged in by voluntary sector organizations.

- Prevention models will be developed for university populations; for parents and families; and for children of alcoholic people.

- In addition to mounting action programs targeted toward children and youth, an attempt to increase knowledge related to teenage drinking patterns and teenage alcohol abuse will be pursued through research projects covering the prevalence and incidence of alcohol abuse among school drop-outs; further exploration of teenage poly-drug abuse; and studies of the use of alcohol by youth within the context of the family and parent/child relationship.

- The development of a new national consensus concerning the use of beverage alcohol -- one which will result in a safer American drinking environment -- will be a long-term process requiring an ongoing, increased prevention thrust and greater support for prevention programs.

V. EDUCATION AND TRAINING

The extramural training program of the Institute has grown from nothing to a significant level of activity over the past five years. Its primary objective during this period has been to effect changes in attitudes and behavior toward alcoholic people and problem drinkers through the development of qualified personnel in the areas of prevention, treatment, and rehabilitation. In support of this effort, NIAAA has established the National Center for Alcohol Education and regional Area Alcohol Education and Training Programs, as well as funding both training grants and fellowships. A major focus of the alcoholism training grants has been to foster the inclusion of alcohol information in the curricula of such professional fields as medicine, social work, public health, psychiatry and psychology.

- Under its legislative mandate for manpower development, the Institute established the National Center for Alcohol Education (NCAE) in May 1973. Its primary goal is to improve the effectiveness of alcohol-related services through the education of policy makers and the development of curriculum materials and model training programs which can be widely used by practitioners in the field. All NCAE programs are in response to two comprehensive and critical areas of need: qualified manpower resources to address the problems of alcohol abuse and alcoholism; and the coordination of services to prevent and treat the manifestations of those problems. The spectrum of educational activities undertaken by the Center includes the design and delivery of seminars and training programs, materials production, data collection, an experimental education laboratory, and the improvement of communication and links among program and training colleagues across the country. Curricula have been developed at the Center for many groups concerned with prevention and treatment of alcohol problems, including trainers, community organizations, volunteers, professionals, policymakers, and alcoholic people and their families. Self-contained modular training packages in readily adaptable formats are being developed to promote effective training and education programs at local and regional levels. The Center has also established a close working relationship with most of the summer schools of alcoholism throughout the country.

- Four regional Area Alcohol Education and Training Programs (AAETP) have been established to meet the manpower needs which are an overriding concern in the field of alcoholism. To help alleviate the problem of a lack of qualified personnel, these area programs in conjunction with the Institute's National Center for Alcohol Education are intended to improve public educational and manpower services to alcohol prevention and treatment programs. While the Institute and the Center provide a national sense of direction on alcohol training, the main thrust of the AAETPs is in the development and coordination of area, State and local efforts to enhance the delivery of education and training, as well as closing gaps in prevention and treatment programs. This effort includes upgrading qualifications of personnel, promoting alcoholism training among other service providers; meeting the specialized education needs of target populations, and educating the public in order to facilitate

early identification of alcoholism problems. Currently there are four AAETPs, headquartered in Atlanta (Southern Region), Chicago (Midwestern), Hartford (Eastern), and Reno (Western). The regional organizations were set up by boards of trustees representing public and private alcoholism project interests, and are expected to become self-financing within three years.

NEEDS AND CHALLENGES: EDUCATION AND TRAINING

- There is a need for the collection of baseline data to determine human resources needs in the alcoholism field.
- An examination must be undertaken of how changes in the total health care delivery system of the Nation would affect the type and numbers of trained persons needed in the alcoholism field.

VI. RESEARCH

The causes of alcoholism are not yet completely understood, but it is believed to involve a complex interaction of biological, psychological and social factors. To obtain a better understanding of its causes, natural development, and treatment modalities, the Institute has supported a wide range of research in all relevant disciplines. The scope of the research grants have covered such major areas as biomedical studies, treatment, socio-anthropological and genetic-ethnic research.

In addition to studies on the causes of liver cirrhosis, other alcohol-related diseases, and the mechanisms and enzymes reponsible for metabolism of alcohol, continued research has been sponsored in such areas as the effects of alcohol on the neurochemistry of the brain, the interrelation between alcohol ingestion and vitamin deficiency, and the effects of alcohol on nerve cell membranes.

Other Institute-supported studies have been focusing on developing pharmacological agents possibly useful in blocking the effects of alcohol on the brain, for long-acting micro-encapsulated agents which would reduce alcohol intake, and for identifying certain natural ingredients which include sensitivity to alcohol.

Animal analogues of alcoholism research studies have been aimed at determining how various subhuman species can be utilized to obtain information on alcohol effects, dependence and tolerance; hopefully, the findings can be extrapolated for greater understanding of these problems in humans.

Specific treatment methods have been studied from various perspectives such as pharmacologic, behavioral-psychiatric, and community systems. For example, the effectiveness of drugs causing adverse reactions when used in combination with alcohol and the utilization of other drugs primarily used as antidepressants in treating alcoholism are being evaluated. Behavioral-psychiatric approaches to treatment include aversive conditioning and other behavior modification approaches (e.g., Alcoholics Anonymous). Community systems involved in the changing approach to managing public inebriates are also being studied and evaluated.

In addition to grant support of research investigations, the Institute has been operating its own research activities. The intramural Laboratory of Alcohol Research conducts interdisciplinary analyses of the basic biological and behavioral relationships of alcoholism in man, attempting to develop new treatment modalities for treating alcoholic people. It also has been using experimental animals to examine the development of alcohol addiction.

- The number of research grant applications received during FY 1975 was 226, and this represents a 125% increase in applications received over FY 1971. This growth in research grant applications reflects an increasing awareness on the part of researchers of the importance of alcoholism as a public health problem.

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- As reported in the Second Alcohol and Health Report, over the past five years research in the alcoholism field has advanced the knowledge of the biomedical aspects of alcohol in many areas, including the relationship between alcohol and cancer, the heart, liver disorders, heredity, mortality, and the central nervous system.

- The research focus in the alcoholism field has been broadened beyond predominantly biomedical concerns to include active investigations of psychological and social factors as well.

NEEDS AND CHALLENGES: RESEARCH

- How alcohol intoxicates and how alcohol addiction develops remain outstanding fundamental questions that require intensive research in several disciplines.

- Further research investigation is needed of findings in the areas of cancer, heart disease, liver disorders, pregnancy and fetal health, aging, mortality, and brain function and their relation to alcohol.

- The Institute research budget has been shrinking relative to other program needs.

- The development of a viable intramural research program of excellence, including adequate facilities and manpower for meaningful clinical studies, should be a high priority.

VII. EVALUATION

An established policy of the Institute has been to include an evaluation component in all sponsored alcoholism programs and projects. Monitoring and evaluation activities presently cover research, prevention, direct services and training. They are designed to assure effectiveness and efficiency in the use of public funds in support of alcoholism programs and to provide guidance in the selection of appropriate alternatives.

- A routine data collection and monitoring system was originally developed for continued monitoring of the 44 community-oriented Alcoholism Treatment Centers(ATCs) funded by the Institute. The system was pilot tested in the ATCs in early 1972 and fully implemented in all ATCs by October 1972. It was designed to gather data from individual projects funded by NIAAA and, through appropriate computer programming, provide reports which show the relationships between program services, management, and client outcome. Since 1972 the system has been expanded to include the following characteristics:

  -- Operational in six NIAAA direct services programs covering 101 treatment and rehabilitation projects;

  -- Provides routine output reports to NIAAA, HEW Regional Offices, States and participating projects, covering program management, client data, and treatment outcome information;

  -- Maintains confidentiality of client records and client identities;

  -- Monitors project resources in terms of staffing patterns and staff utilization, expenditures, revenues from all sources, and services provided -- including inpatient and outpatient care; provides service unit costs and trend data by project.

  -- Used for descriptive statistics, accountability, effectiveness and input for periodic program evaluation;

  -- The most comprehensive health service monitoring system in the Federal government.

- Findings from the routine outputs of the monitoring system were supplemented by a longer term follow-up study on the treatment and outcome of a group of clients served by a sample of ATCs. This information, covering an 18-month period after treatment, is being used to improve the cost effectiveness of ATC programs and to identify benefits received from various amounts and types of treatment, as well as to determine treatment patterns and modes appropriate to clients with various intake characteristics. The data are also being used to determine how to retain clients in treatment more successfully, and to investigate the reliability of routinely collected six-month follow-up data. Findings indicate that more effective utilization

of treatment resources, coupled with a growing emphasis on outpatient care, has led to a marked increase in treatment effectiveness, with 65-70% success rates being achieved. This success has helped increase the earning capacity of patients by 42% at 18 months and has led to an 81% decrease in hospital utilization for all health and medical problems. At six months after entry into treatment, these client benefits alone more than offset the amount of Federal dollars spent on these treatment programs.

- Targeted evaluation surveys have been conducted by the Institute in such specific areas as alcoholism programs for various minority groups, youth involvement in NIAAA programs, and the impact of the NIAAA mass media education campaign. Periodic surveys have compiled data and provided information on the drinking behavior and attitudes regarding alcoholism existing in the general population.

- The Institute is putting in place a formula grant program data system to gain information on the effectiveness of State alcoholism programs, which receive significant support from Federal funds. In order to evaluate performance with respect to required State plans submitted to NIAAA, the Institute is collecting data annually in the following areas for each State:

  -- State alcoholism program staff positions;

  -- Assignment of staff and allocation of funds by source within functional areas;

  -- Numbers of programs in each functional area by method of support;

  -- Numbers of admissions into State-assisted programs by age, sex, race, and type of program;

  -- Numbers of alcoholism staff certified or licensed by the State;

  -- Numbers of facilities accredited in the State.

  An intensive 18-month effort funded partially by NIAAA is presently being undertaken in Texas to determine the effectiveness of a State aftercare program and the success elements in that program.

- The National Technical Assistance and Monitoring Program was launched in April 1975 as an extensive attempt to assure continued high quality effectiveness of approximately 440 NIAAA-funded community service programs. One prime contractor and two sub-contractors are working with NIAAA staff in providing technical assistance and monitoring systems, utilizing an automated scheduling system that assures each grantee access to these two types of services. In addition, by this process timely reports are provided the Institute to be used in decisions regarding future funding.

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NEEDS AND CHALLENGES: EVALUATION

- While the level of Institute funding grew more than 15-fold from FY 1971 to $218.5 million (including released impounded funds) in FY 1974 the size of the NIAAA staff remained substantially the same, severely limiting our capability to administer, monitor, and evaluate Institute-funded programs.

- Severe travel restrictions have hampered the ability of Institute staff to conduct evaluation activities.

VIII. SUMMARY

The record of the National Institute on Alcohol Abuse and Alcoholism over the past five years has been one of strong commitment and important progress in the battle against alcohol abuse and alcoholism. We have played a significant role in leading the Nation from decades of ignorance and neglect of alcohol problems into the beginning of a new era of commitment and concern for alcoholic people. However, it is only a beginning; for as far and as quickly as we have come, we still have the longest part of the journey before us in our Nation's effort to deal with this complex human problem.

FUNDAMENTAL FIVE-YEAR ACCOMPLISHMENTS

- The National Institute on Alcohol Abuse and Alcoholism has been established as the focal point of continuing Federal leadership and commitment to the problem of alcohol abuse and alcoholism.
- Funding for the Institute has increased from $14 million annually to a high yearly funding level of $218.5 million, reflecting increased governmental and public concern for alcohol-related problems and the enormous toll they exact from our society.
- There has been growing public recognition and acceptance of alcohol as a drug and alcoholism as a treatable illness.
- The increasing awareness of alcohol-related problems among the general public has led to a growing public interest in and demand for their resolution.
- A vast grassroots constituency, never before interested in alcohol-related issues, has been created.
- There has been significant progress in the enlargement of the professional alcoholism treatment constituency and the establishment of related organizations; this growth has reinforced and augmented the volunteer movement, which was the pioneering force in the alcoholism field and remains the largest force in the field today.
- State and local leadership initiatives have been developed through such decentralizing efforts as the formula grant program, the State prevention coordinators, and the emplacement of occupational program consultants.

FUNDAMENTAL NEEDS AND CHALLENGES

- The National Institute on Alcohol Abuse and Alcoholism must work more creatively to overcome budget and personnel shortages.
- The implementation of international cooperative efforts has only just begun, and the international alcoholism thrust must be greatly expanded.

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- Too many treatment programs still concentrate on late stage chronic alcoholism, maintaining a rigid approach that focuses on removal of a substance instead of on restoration of function by responding to the unique unmet needs of each alcoholic individual.

- Despite the expansion of alcoholism treatment services, the vast majority of alcoholic people still do not have available the treatment they require.

- There is a strong need to overcome ambivalence surrounding alcohol use, and erase the fixed stereotype of the alcoholic person as unmotivated, untreatable, and inherently to blame for his illness.

- The establishment of accepted cultural standards for alcohol use must be made a high, long-term priority; the adoption of such standards have the strong potential for reducing problems through the development of safer drinking practices, and facilitating the ability of society and individuals to identify and treat earlier those who are developing drinking problems.

- Although the importance of comprehensive prevention programs tailored to community needs has gained significant recognition over the past five years, implementation efforts have only just begun.

- Finally, the alcoholism field must take care not to permit the successes of the past from leading to fragmentation, pettiness, and territorial bickering at the expense of alcoholic people.

APPENDIX

FIRST SPECIAL REPORT TO THE U. S. CONGRESS ON ALCOHOL AND HEALTH
FROM THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE (December 1971)

Findings

The Task Force Finds That:

- Alcohol is the most abused drug in the United States. The extent of problems related to alcohol abuse and alcoholism is increasing and has reached major proportions.

  An estimated 7 percent of the adult population in the United States manifest the behaviors of alcohol abuse and alcoholism. Among the more than 95 million drinkers in the Nation, about 9 million men and women are alcohol abusers and alcoholic individuals.

  The most visible victims of alcoholism are inhabitants of skid rows across the Nation. Yet they represent only from 3 to 5 percent of the alcoholic population in the United States. Most alcoholic individuals are in the Nation's working and homemaking population. It has been estimated that as many as 5 percent of the Nation's work force are alcoholic individuals and that almost another 5 percent are serious alcohol abusers.

  Alcohol plays a major role in half the highway fatalities in the United States, and cost 28,000 lives in one recent year. The ratio of alcohol-related traffic fatalities is even greater among youths age 16 to 24; among these young people, the proportion rises to six out of 10 highway deaths.

  Alcohol abuse and alcoholism drain the economy of an estimated $15 billion a year. Of this total, $10 billion is attributable to lost work time in business, industry, civilian government, and the military . . . $2 billion is spent for health and welfare services provided to alcoholic persons and their families . . . and property damage, medical expenses, and other overhead costs account for another $3 billion or more.

  Public intoxication alone accounts for one-third of all arrests reported annually. If such alcohol-related offenses as driving while under the influence of alcohol, disorderly conduct, and vagrancy are considered, the proportion would rise to between 40 and 49 percent.

  Among American Indians, the incidence of alcoholism is at an epidemic level. The rate is estimated to be at least two times the national average. On some American Indian reservations, the rate of alcoholism is as high as 25 to 50 percent.

- Alcohol abuse can impair health and lead to alcoholism.
- Alcoholism is not a crime. It is an illness or disease which requires rehabilitation through a broad range of health and social services tailored to persons at different stages of alcohol abuse and alcoholism.
- The criminal law is not an appropriate device for preventing or controlling health problems. To deal with alcoholic persons as criminals because they appear in public when intoxicated is unproductive and wasteful of human resources.
- The causal factors of alcohol abuse and alcoholism are not yet established. Social, psychological, physiological, and cultural factors all play roles in their development and course. The full understanding of these factors and their interrelationships awaits further study.
- Many minority groups in our society have experienced exceptional deprivations. For these disadvantaged citizens, heavy drinking has accentuated or been a response to such hardships as limited access to job opportunities, unequal housing and schooling, and inadequate medical care.
- In addition to intoxication, the illnesses associated with alcohol abuse and alcoholism include emotional disorders and chronic progressive diseases of the central and peripheral nervous systems and of the liver, heart, muscles, gastrointestinal tract, and other bodily organs and tissues.
- Scientific research has made progress in understanding the metabolic course of alcohol through the body. Nevertheless, we still lack important knowledge of the complex and interactive role that alcohol plays in producing some of the biochemical changes and physiological damage seen in heavy drinkers.
- Present programs dealing with alcohol abuse and alcoholism are accorded a low priority and are unrelated to most of the health and social resources within communities. Existing research, as well as social, health, and rehabilitation laws and activities have not been effectively mobilized to solve the problems of alcohol abuse and alcoholism. These inadequacies have contributed to the inability of many private and public national,

State, and local institutions, agencies, and organizations to recognize their responsibilities for meeting alcohol-related problems.

- Too often the only community health resource for acutely intoxicated individuals is an emergency facility commonly known as a detoxification center. When isolated from other human services, these centers duplicate the "revolving door" syndrome long associated with repeated incarceration, rather than providing for the rehabilitation of alcohol abusers and alcoholic persons.
- Establishment of modern public-health oriented facilities to deal with intoxicated persons will free police, courts, correctional institutions, and other law enforcement agencies from being overburdened by a large population of ill people. It will also facilitate:

  Early detection and prevention of alcoholism.

  Effective treatment and rehabilitation of alcoholic persons.

  Early diagnosis and treatment of other diseases caused by, exacerbated by, or coexisting with alcohol abuse and alcoholism.
- Although many communities do provide some treatment facilities for persons with alcohol-related problems, these services are frequently fragmented and fail to take into account either changing life styles or the unique characteristics of various population groups. Thus, alcohol abusers and alcoholic individuals may be deterred from seeking or accepting help in the communities where treatment should be readily accessible and designed for their specific needs.
- Many public and private general hospitals have not yet implemented the position taken by the American Medical Association and the American Hospital Association that no patient be excluded from hospital care because his illness is identified as alcoholism. As a result, many physicians are still forced to make subterfuge diagnoses so patients can gain hospital admittance for treatment of alcoholism. This situation reinforces society's denial that alcoholism is a significant health problem and thereby undermines attempts to develop effective methods of prevention and treatment.
- Minimal success has been achieved by our traditional, punitive methods of dealing with persons who drive while under the influence of alcohol. Research findings indicate that a therapeutic approach to the problem of drinking drivers holds a greater promise of reducing the incidence of alcohol-related traffic accidents.
- Employment-connected alcoholism programs have demonstrated their therapeutic value.
- Faced with shortages of professional personnel and increasing demands for service, many alcoholism programs have demonstrated that the ability to care for people is not built into any one profession. A variety of professional and trained paraprofessional persons, and trained members of such voluntary groups as Alcoholics Anonymous, can serve as effective providers of therapeutic and rehabilitative services.
- Historically, difficulties have been experienced in planning necessary long-range programs to provide training, services, and preventive activities because of the lack and uncertainty of adequate financial support for alcoholism programs.
- Test cases, Crime Commission reports, and even adoption of progressive new uniform legislation, do not guarantee the provision of adequate and appropriate treatment and rehabilitation services. They merely provide the statutory framework within which a State can undertake to handle the problems of intoxication and alcoholism according to the best current knowledge. Implementation is up to the will of the State, and can be demonstrated only by appropriate funding and the dedication of the health, welfare, and rehabilitation resources necessary to do the job.
- Alcohol abuse and alcoholism are recognized as major health problems in most developed and many developing nations. Despite the global nature of these problems, however, there has been little multinational cooperation aimed to develop more effective methods for combating alcohol abuse and alcoholism.
- No battle against a public health problem can gain a significant victory if it attends only to the casualties. Appropriate treatment of persons who are abusing alcohol—the primary condition that may lead to alcoholism—can intercept the development of many cases of alcoholism. Yet much of the work in the field of alcoholism has been focused on treating late-stage victims of the disorder. Programs that are exclusively therapeutic or rehabilitative will not result in long-term conquest of the problem unless ways of preventing new cases of alcoholism are developed.

Programs

In Response to the Findings of the Task Force, the Secretary of Health, Education, and Welfare Is Establishing Programs Within the National Institute on Alcohol Abuse and Alcoholism, and Coordinating All Departmental Research, Prevention, and Treatment Programs, To Develop and Implement a Detailed, Comprehensive Federal Plan Designed to:

(1) Evaluate the adequacy and appropriateness of any provisions relating to the prevention and treatment of alcohol abuse and alcoholism in all State health, welfare, and rehabilitation plans submitted to the Government in accordance with Federal law.

(2) Assist such Federal Departments as the Civil Service Commission, Department of Defense, Department of Housing and Urban Development, Department of Transportation, Department of Labor, Department of the Interior, Office of Economic Opportunity, and Veterans' Administration; and such DHEW agencies as the Social Security Administration, Indian Health Service, National Institute on Occupational Health and Safety, Social and Rehabilitative Services; and other Federal departments and agencies in developing and maintaining appropriate prevention and treatment programs for alcohol abuse and alcoholism.

(3) Assist State and local governments in coordinating programs among themselves for the prevention and treatment of alcohol abuse and alcoholism, and provide assistance and consultation to local governments and private organizations with respect to prevention and treatment of alcohol abuse and alcoholism.

(4) Encourage States to adopt the Uniform Alcoholism and Intoxication Treatment Act, and provide technical assistance to help States implement this Uniform Act.

(5) Establish a clearinghouse of information to gather, systematize, maintain, and make widely available—in appropriate contexts and languages to all sectors of the population—the knowledge on alcohol abuse and alcoholism.

(6) Make available research facilities and resources to appropriate authorities, health officials, and individuals engaged in special studies related to the prevention, control, and treatment of alcohol abuse and alcoholism.

(7) Formulate and publish criteria of quality treatment for alcohol abuse and alcoholism, and require that all programs supported by the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 meet such criteria.

(8) Issue regulations that establish State standards that require providers of services for alcohol abuse and alcoholism to offer a continuum of care ranging from emergency treatment for acute intoxication, to outpatient therapy, to residential centers for the small number of alcoholic individuals unable to return to unsupervised life in the community.

(9) Establish interdisciplinary training programs for professional and paraprofessional personnel with respect to alcohol abuse and alcoholism; develop guidelines and courses to educate health and social workers about the factors contributing to alcohol abuse and alcoholism; and provide training for health, education, and other professionals to help them become leaders, teachers, researchers, and program developers in this field of public health.

(10) Develop regulations for training grants that establish standards of education and experience for professional and paraprofessional workers who provide treatment services to alcoholic persons.

(11) Recruit and train paraprofessional workers, including recovered alcoholic persons and other individuals whose life experiences enable them to bring special empathies to this work, to serve in community services for the prevention and treatment of alcohol abuse and alcoholism.

(12) Stimulate programs of research designed to understand the uses and abuses of alcohol, and the processes of alcohol addiction or dependence, particularly with respect to elucidating the mechanisms by which alcohol acts as a central nervous system intoxicant.

(13) Stimulate and support multinational cooperation and collaboration in undertaking basic and applied research concerning the causes of alcohol abuse and alcoholism, and the most effective methods of combating them. Such investigations should include international epidemiological studies as well as evaluations of the effectiveness and costs of different treatment modalities and delivery systems.

Findings

- Alcoholism and alcohol misuse continue to occur at high incidence rates within American society.
- The proportion of American youth who drink has been increasing. Most adolescents have at least tried alcohol, and the highest scores on an index of possible problem-drinking behaviors were recorded in the youngest age group for which data are available, the 18-20 year olds.
- The public suffers from much ignorance concerning alcohol and from ambivalent feelings toward it. Worse yet, heavier drinkers know less about alcohol than do lighter drinkers or abstainers. In general, American attitudes about drinking are marked by confusion and dissent.
- The economic cost associated with misuse of alcohol in the United States is estimated at $25 billion a year.
- The U.S. systems of alcohol controls are chaotic relics. They provide little support in mitigating alcohol problems and may induce a counterproductive ambivalence among the public.
- The excessive use of alcohol, especially when combined with tobacco, has been implicated as increasing the risk of developing certain cancers. Nonwhite men appear to be especially susceptible.
- Heavy drinking during pregnancy can adversely affect the offspring of alcoholic mothers. The significance of heredity in alcoholism is as yet unresolved.
- The development of a new animal model of liver cirrhosis gives promise of resolving the problem of cause in one of the severest damages suffered by alcoholic people, and may contribute to more effective treatment, and prevention.
- Moderate consumption of alcohol is generally not harmful. In some cases, such as among the elderly, it may have beneficial physical, social, or psychological effects.
- The nonexcessive use of alcohol does not appear to adversely affect the overall mortality rate, nor the mortality from a specific major cause of death, coronary heart disease. In fact, the mortality of drinkers is lower than that of abstainers and ex-drinkers.
- How alcohol intoxicates and how alcohol addiction develops are outstanding fundamental questions that require intensive research in several disciplines.
- Alcoholism is a treatable illness, but different treatments are required by different individuals. Increasingly, individual treatment needs can be determined on the basis of valid studies or clinical experience.
- Early identification and treatment of alcoholic people are seriously constrained by the fact that the United States lacks a national consensus on what constitutes responsible use of alcohol. Furthermore, the current lack of parameters with regard to safe versus comparatively unsafe drinking patterns provides an inadequate and ineffective clinical base for the diagnosis of alcoholism.

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- Although the accessibility and quality of alcoholism treatment services are improving, a serious deficit of such services remains, and only a small portion of alcoholic people are receiving the services they require. Moreover, the bulk of treatment services which are available are designed for late-stage alcoholism and do not meet the needs of people in earlier identifiable stages of the illness.

- Major strides can be made in providing adequate treatment for alcoholism with more effective utilization of resources and personnel. This goal requires continuation and expansion of the roles played by the private and voluntary sectors of society.

- Treatment programs supported by business and industry can be especially effective in earlier identification of employees with alcohol problems, and such programs report the highest rates of recovery.

- Third-party coverage for alcoholism treatment costs is essential, and feasible, to provide adequate services for all who require such treatment.

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Recommendations

On May 14, 1974, the President signed Public Law 93-282, continuing and giving renewed emphasis to the Nation's settled commitment to deal with alcohol abuse and alcoholism as initially expressed by the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970. The new amendments build on the experience since 1970 and sharpen that comprehensive commitment:

> "It is the policy of the United States and the purpose of this Act to (1) approach alcohol abuse and alcoholism from a comprehensive community care standpoint, and (2) meet the problems of alcohol abuse and alcoholism not only through Federal assistance to the States but also through direct Federal assistance to community-based programs meeting the urgent needs of special populations and developing methods for diverting problem drinkers from criminal justice systems into prevention and treatment programs."

On the basis of this legislative mandate and the findings of this *Report*, the Secretary of Health, Education, and Welfare recommends—

THAT THE GROWING STORE OF KNOWLEDGE ABOUT ALCOHOL AND ALCOHOLISM BE MADE MORE READILY AVAILABLE FOR USE BY SPECIALISTS AND THE PUBLIC.

The need to systematize and process the growing world-wide experience, study, and research so that it will be available to scholars, researchers, legislators, educators, administrators, professionals, and all citizens is critical. The further development of the National Clearinghouse for Alcohol Information, in collaboration with appropriate academic and other sources, should therefore be pursued energetically.

THAT EDUCATIONAL RESOURCES FOR PROFESSIONALS AND SCHOOLS BE EXPANDED AND DEVELOPED.

The rehabilitation of problem drinkers and alcoholic people requires the help of a wide variety of professional and allied personnel with special skills and understanding. Resources for the training and accreditation of such specialized personnel should be identified in model form, and States or regional consortiums should be encouraged to adopt these approaches as appropriate to their own needs.

The long-range prevention of alcohol misuse depends in part on the transfer of knowledge about alcohol, and the understanding of its use and nonuse, to the younger generation. Schools throughout the Nation have an important role in this process. Suitable modules of alcohol education should be developed by the National Center for Alcohol Education and Regional Centers. State and local school systems can adapt these modules for their curriculums.

THAT EFFORTS TO DECRIMINALIZE AND INSTEAD PROVIDE COMMUNITY CARE FOR ALCOHOLISM AND PUBLIC INTOXICATION BE REDOUBLED.

The Uniform Alcoholism and Intoxication Treatment Act recommended to the States by the National Conference of Commissioners on Uniform State Laws and by the Secretary of Health, Education, and Welfare provides a model for States to decriminalize alcoholism and public intoxication and establish the legal framework within which to approach them from a community care

standpoint. This action has been recommended by the courts, Presidential Commissions, and professional organizations. A special grant in Public Law 93-282 to States that adopt this legal framework and approach is a fundamental recognition of its importance by Congress and the Administration.

THAT THE NEW LAWS PROTECTING THE PRIVACY AND CONFIDENTIALITY OF ALL CITIZENS WITH DRINKING PROBLEMS BE STRICTLY AND IMMEDIATELY ENFORCED.

Public Law 93-282 amends section 333 of the Alcoholism Act to provide the first comprehensive approach to the issue of confidentiality and privacy for people with drinking problems.

THAT EFFORTS BE SPEEDED UP TO ASSURE QUALITY CARE FOR AND TO REDUCE THE CARNAGE OF ALCOHOLISM AMONG SPANISH-SPEAKING AMERICANS, INDIANS, AND OTHER NATIVE AMERICANS, YOUNG BLACK MEN, AND HIGHWAY TRAVELERS.

THAT THE VALUES OF EARLY IDENTIFICATION AND TREATMENT PROGRAMS IN BUSINESS AND INDUSTRY BE GENERALLY RECOGNIZED THROUGHOUT THE COUNTRY.

The magnitude of the cost to the Nation's economy stemming from problem drinking and alcoholism is staggering. It is imperative to encourage the wider establishment, in Government as well as in the private sector, of the types of program that, with the cooperation of labor and management, have successfully restored substantial majorities of affected personnel to health and normal function. The economic benefits of effective early identification and treatment programs demonstrably outweigh the cost, and the human benefits are beyond valuation.

THAT QUALITY AND COMPREHENSIVE CARE BE EXTENDED TO ALCOHOLIC PEOPLE THROUGH COVERAGE UNDER HEALTH AND DISABILITY BENEFITS AND THE ESTABLISHMENT OF STANDARDS FOR CARE.

Total coverage for the treatment of alcoholism through traditional and other third-party payment plans should continue to be studied. The application of such coverage in both general and special therapeutic settings should be explored, with particular consideration to the continuum of health and human-service needs of alcoholic people in the process of recovery and rehabilitation. Standards and certification for such care are crucial to insurance coverage and to the quality of care that can be obtained by alcoholic people.

THAT NEW AND REVISED POLICIES AND GUIDELINES GOVERNING THE DISTRIBUTION AND SALE OF ALCOHOLIC BEVERAGES BE DEVELOPED.

Current laws and regulations need to be reevaluated to determine whether they are fulfilling their intended purposes. To the extent that they are not, a set of model codes of alcohol-beverage control should be formulated, which States and communities may adopt with modifications to suit their own needs.

THAT IT BE RECOGNIZED THAT THE MULTIPLICITY AND EXTENT OF ALCOHOL-RELATED PROBLEMS CANNOT BE THE EXCLUSIVE RESPONSIBILITY OF THE FEDERAL GOVERNMENT. ACCORDINGLY WE SHOULD FIND WAYS—

To strengthen the involvement and the role of private enterprise in reducing the problems of alcohol misuse and alcoholism;

To enhance the role of voluntary agencies, and support by State and local governments, in activities related to the care of the afflicted, and in contributing to preventive efforts.

THAT EFFORTS BE MADE TO INTENSIFY THE STUDY OF THE RELATION OF ALCOHOL USE TO—

Cancer
Heart disease
Liver disorders
Pregnancy and fetal health
Aging
Longevity and mortality
Brain function and the addictive process

THAT A NEW NATIONAL CONSENSUS CONCERNING WHAT CONSTITUTES RESPONSIBLE USE AND NONUSE OF ALCOHOLIC BEVERAGES BE FORMULATED AND ARTICULATED.

Current concepts and mores concerning the use and nonuse of alcoholic beverages are confused, inconsistent, and sometimes destructive. Knowledge about the use and misuse of alcohol needs to be shared more widely and continually so that citizens and especially our young people are given the opportunity to base their decisions to drink or not to drink on the best information that is available. In addition, new and alternative recreational and social settings may be considered in which drinking will be a coincidental function rather than the main reason for people frequenting them.

Mr. ROGERS. Thank you very much, Dr. Chafetz, for a very helpful and enlightened and important statement. We appreciate your presence here.

Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

You spoke of the inverse pyramid, which refers to the fact that the ones who need treatment the most get the least. Could you explain that a little further?

Dr. CHAFETZ. Yes sir. One of the interesting studies that was done before I came to Government was done at McLean Hospital at Harvard, Dr. Carter, and a study of resource allocations showed that the psychiatrists who were at the top of the hierarchy had the grestest number of resources allocated to them, and then to the psychologists and nurses, and so forth, with the patients receiving the fewest number of resources.

In our programs that tends to be replicated. In other words, administrative costs, in order to support the caretaking personnel, seem to take a big hunk of the pie. I believe that could be cut back and I think that has been shown, for example, in some of the studies.

The Blue Cross of Maryland appears to be willing to offer benefits to nonhospital residential alcoholism programs and outpatient care in nonhospital situations, where at lower costs they have higher outcome effectiveness.

I think we have to look at that.

Mr. CARTER. I certainly agree with you.

I have done a little investigation myself, and the Kentucky Mental Health Association is in agreement with you. Of course, they supported the legislation. They say too much is being spent at the base of the inverted pyramid.

Dr. CHAFETZ. Yes, sir.

Mr. CARTER. The reported upsurge problem of drinking among the young is particularly disturbing.

What do you consider is the cause of this, and what is being done to deal with it?

Dr. CHAFETZ. I am as troubled as you are, Dr. Carter. In "Alcohol and Health No. 2," which we released in a White House press conference in, I believe, July of 1974, we had completed the preliminary findings of a large survey of the drinking behavior of young people in this country.

As you probably know, for the Harris poll, for some of the other polls, the sampling procedure is usually to use anywhere from 800 to 1,500 people as their sample population. Because of the nature of this particular area, we had a sampling of 15,000 young people between the ages of 12 and 17, and found some very serious findings.

For example, between the ages of 12 and 17, 5 percent of these young people get drunk, overdose with the drug, alcohol, at least once a week. That is more than 52 times a year. When you realize you are dealing with some young people who are 12 years old, and you then take your cut at higher grade levels by age 17 in grade 12, the incidence of overdosing with the drug, alcohol, getting drunk at least once a week, rises to 14 percent of the population.

Then when you look at the fact that at grade 10, 50 percent of them report drinking at night in cars, you understand why for the

total population of drivers in the United States 40 percent of the traffic fatalities are alcohol related; but in the age group between 16 and 24, it is 60 percent of the fatalities which are related to heavy alcohol abuse and traffic fatalities. That is a very serious situation.

And one of the last activities I engaged in was setting new priorities for the Institute and the setting up of youth programs was naturally one of them.

You asked for the cause. Well, sir, psychiatrists, as you know, operate on the wisdom of hindsight. We are brilliant with the wisdom of hindsight, but our prospective, prophetic wisdom leaves something to be desired.

I would tell you the reason I believe that young people are abusing alcohol is because we as adults, their role models, are also abusing alcohol. We, as a nation, think it is all right to get drunk and overdose with the drug, alcohol. We think that the expression of prowess is expressed by consuming great amounts of alcohol. We give an inordinate focus on alcohol in our society to place it in a position that it does not deserve.

If anyone thinks I am against drinking, do not believe that. I think alcohol has an important place to play in our society but I don't think it is that hot a thing which measures success and all the rewards of the good life and all the things the young people are taught.

The young people of America have switched from the other drugs, as our studies show, back to alcohol, and in a circumstance such as this country has of few measurements of success, alcohol is one of the measures of adult status and, as a consequence, I think they focus heavily and increasingly with this emphasis on this substance leading to these problems, and we need to have a prevention educational program to put it into perspective.

Mr. CARTER. Could you describe some of your activities in the prevention of alcohol abuse?

Dr. CHAFETZ. Yes, sir. Prevention, Dr. Carter, of course, is like motherhood, everyone is in favor of it, and I have never found anyone who stated they were against it. But unfortunately this is a great technological society and we like to think that once you put in a single change, your outcome will be automatically effected.

If I may, the closest model for that is the acute infectious model, and you and I are familiar with that as a nice, simple model with the organism that causes symptoms, which either have a treatment or they don't, and they live happy ever after.

I would like to remind the public of the fact you and I know that the simplest example is that of smallpox, which is in the acute infectious model and for which we have a neat vaccination that is cheap to produce, easily transportable, easy to introduce to the individual and the world—we have had it for 200 years—and the World Health Organization is just saying that we are now just eradicating it; this with a simple model.

With a complex issue like alcoholism I don't want to make it an oversimplified situation. I think this society has to decide what are the responsible limits of using alcohol. It will do two things because it will comfort the American public which is very ambivalent, confused, guilty, and conflicted by its own use of alcohol.

But it will have a more important health issue. It will allow us to recognize those individuals who are having abnormal responses to the

use of alcohol earlier, and I know this committee is recognizing and examining a bill about prevention and promotion of health issues.

I think, Dr. Carter, that, for example, there was an article in today's Washington Post about malignancy. We have been spending all this money on looking for causes and cures where all of us know that if malignancy could just transmit to us its presence earlier, we probably could satisfactorily cause recovery in 95 percent of the people who are suffering from malignancy.

You know it is a truism of every health and social issue the earlier you recognize it and intervene, the quicker, the better outcome at lower cost. This holds true of alcoholism. With the state of the art at present, people have to be very sick, very far down the road before we recognize it and treat them, and that is why it is so costly and why therapeutic nihilism exists.

The first thing is to come up with a system that allows us to identify alcohol problems earlier. We think the evidence is there to provide that system for the Nation, and it will require a lot of public awareness activities through the clearinghouse, and the development of constituencies, and that is why we have gone to these community organizations things because education is not just the provision of information, putting out fancy booklets, or having Dr. Chafetz lecture and people will be changed forevermore. It is an ongoing community process that involves local sanctions and education where the attitude toward alcohol becomes part of the life experience, rather than something that is information alone.

I could go on an on—I get wound up about this. I apologize for my lengthy response.

Mr. ROGERS. Mr. Hefner?

Mr. HEFNER. Thank you, Mr. Chairman. I am happy you mentioned "fancy booklets." I think it is kind of ironic because yesterday at the Giant supermarket in McLean, Va., I happened to pick up a booklet called "Drinking Etiquette," which is dispensed by the U.S. Department of Health, Education, and Welfare.

Dr. CHAFETZ. Yes, sir.

Mr. HEFNER. And in reading through the booklet—of course, I totally abstain from alcohol myself—I cannot see where there is any incentive for anybody not to drink. It tells you how to handle your parties, for instance how to plan if you happen to be having some people from a foreign country come in, what they particularly like to drink, and this type of thing.

In your statement that you alluded to the fact that we had 19 percent, I believe, fewer fatalities on the highways in 1974. Would you say we probably had as many accidents caused by alcohol, but because of the 55-mile speed limit we didn't have the fatalities?

Dr. CHAFETZ. Mr. Hefner, I do not know; and I stated that. If I were asked my judgment, I would tell you the 55-mile limit is probably the main reason. There is some evidence that there has been some change as a result of the activity of the alcohol safety action program out of the Department of Transportation complementary to the treatment programs we established that has gotten people into treatment earlier; but we do not know, in all honesty. I cannot tell you whether or not it is just the slowing down to the 55-mile-an-hour speed limit, while we have the same number of people around on the highways.

We are just too early in the situation to give you an honest response; but we ought to ask about that because, as I understand; people who have severe alcohol problems and have automobile accidents, I cannot see them responding so much to the 55-mile-an-hour limit because we know they did not respond to the removal of licenses, revocation of licenses, and other sanctions imposed on them.

So we do not know—and it is quite possible. But I must also respond to the booklet you have there, "Etiquette of Drinking." I think you must look at it very carefully because one of tne etiquettes of drinking is to give respect to, and not put pressure upon those people who choose not to drink. The Institute's policy has not been to take a position for or against drinking. I think it is eminently incorrect and dangerous for a Federal agency to define morality and behavior in this area for its population. We could only share our best information with them and let them make their own judgment.

I get very worried about it because as a person who has studied history. I have found how often under the guise of goodness societies have imposed harm while they tried to impose some people's self-righteous attitudes to be put on other people.

That "Etiquette of Drinking," as I remember the publication, was a sensitive respect to people who do not drink, and I am sensitive to that even though I do drink, because I am always fighting, Mr. Hefner, the battle of the bulge, and the only way I can succeed that battle of the bulge is to give up alcohol. It increases an already prodigious appetite.

I was struck when I chose not to drink, how many people put pressure upon to drink when I chose not to, and I think these people need not feel different or have that kind of pressure as part of the etiquette of drinking.

Mr. HEFNER. I think it was Abraham Lincoln who said, "Alcohol has many defenders but no defense." I do not argue the case for prohibition but I do think that we have, as Dr. Carter alluded to, a situation in which our young people are moving toward alcohol rather than the other drug cultures. I do not think we have through our television media—even though some kinds of advertising are illegal—put alcohol use in a favorable light. It is used by the beautiful people. On programs on television—detective programs, soap operas, and so on down the line—there is seldom a 5-minute segment during which someone does not say: "Would you come in, would you have a drink?"

It is the thing to do. It is the proper thing to do. The beautiful people do it. The heroes do it. Football players and basketball players do it. I cannot relax until I have a highball, or whatever, before I retire.

I think that I would be the last person in the world to want to exercise censorship, but I think this type of exposure influences people, not only young people, but I think it influences the middle of the road, the housewife, the people who watch television. They see this is the thing to do.

As you said, I do not think the Federal Government should or can legislate morality, or what is right and what is wrong, but I think these are some of the areas that encourage alcohol abuse.

Dr. CHAFETZ. Mr. Hefner, I agree with you. As a matter of fact, the Institute had a study done that monitored the incidence of references to alcohol drinking, getting drunk, and so forth, in the media that found that there was an enormously high emphasis throughout pro-

graming, and the Christian Science Monitor, independent of the Institute, ran its own survey around this same issue and came to literally the same findings of the high incidence.

One of the things I devoted a good part of my last year in office to was to meet with the heads of the television industry, with the Screen Writers Guild, with Mr. Lou Wasserman of MCA, all of these people, to enlist their aid in eliminating alcohol references if it did not interfere with the story content, and they are busy examining this.

I noticed that NRB just came out with a new code for advertising for beer and wine to lessen some of this. They are making some movement. Whether they are moving fast enough is open to question, but they have become aware of the fact instead of their knowing what to do with their hands in a dead scene they reach for a drink, and this has an impact on all levels of society, as you have pointed out, the beautiful people, the success—you are not successful unless you reach for that drink, you work hard all day to get to the bar, that is the only reward for living.

That is pretty sad, and I think that we have to suggest to them that they examine it. I feel we have been doing it. I think they are seriously recognizing the fact that the public is expecting it of them.

Mr. HEFNER. I have no further questions.

Thank you, Doctor.

Mr. ROGERS. I may ask you to answer a few questions for the record, if you would?

Dr. CHAFETZ. Yes, sir.

Mr. ROGERS. I think the testimony you have given us is encouraging, and I think your directorship there at the Institute has led to results with which we are very pleased.

What would be your perception of the effect of terminating Federal alcohol programs and instead simply giving unearmarked money to the States to spend on whatever they might desire?

Dr. CHAFETZ. Mr. Chairman, I do not have to wait to submit that for the record. That would be a disaster because we know that in the priority situations in the fight for money for roads and teachers and policemen, historically alcoholism has been the neglected area. You know we get the short end of the stick, sir, and I think it would be a disaster to remove the Federal initiative at this time.

I think if this society recognizes more completely these are sick people and not bad people that there may come a time to shift the emphasis but we have not reached that level. I think it would be an utter disaster.

Mr. ROGERS. How useful were the State plans in determining the effectiveness of the State programs?

Dr. CHAFETZ. I think I would have to answer that at two levels, Mr. Chairman.

First of all, the legislation and the process by which it was implemented the first year—most of the States did not have good plans but we needed to get them going and we gave them the money with the understanding we would give them technical assistance to implement their plans.

We think there is great improvement coming along. I think the States are doing a reasonable job but I do not believe they are at a level that we can shift the whole responsibility to them.

Mr. ROGERS. Are there any special problems that we are seeing with respect to men drinkers or women drinkers or some other grouping?

Dr. CHAFETZ. The evidence shows that when I first came into the field esome 23 years ago, the ratio was 5½ men to 1 woman. I would suspect on the basis of some of the evidence that women are catching up to men in many areas, including drinking problems. I think it is an unfortunate situation.

This was another priority, women with alcohol problems, that the Institute took on at the end of my tenure.

Mr. ROGERS. Do we have any statistics that would give us an estimate of how many women alcoholics there are?

Dr. CHAFETZ. I would say from the 9 million which you referred to, which was a product of alcohol and health, I would say we could safely say there are 3 million alcoholic women in this country—one-third.

Mr. ROGERS. That seems to be growing.

Dr. CHAFETZ. The evidence seems to be that this is growing; yes, sir.

Mr. ROGERS. What is the role of the regional office with respect to the alcohol program?

Dr. CHAFETZ. Well, I have shared with you my successes, I have shared with you some of the challenges in where we ought to go; I think I ought to share with you some of the things I felt did not go so well, and regional office is one of the situations.

It was a locus, I felt, for effecting the integration of alcohol efforts with the rest of the health care system. One of our goals, you know, I remember saying before the OMB I know the Alcoholism Institute will be a success when we no longer needed the Alcoholism Institute because alcoholic people were being treated in the total health care system, and I believe the regional office mechanism was one way of building alcoholism into all of health care systems.

However, because of the very limited resources that we had for personnel, in order to effect this, we would have had to take from our meager central office staff and put them out into the regional office to accomplish that. I had made them a promise I wanted to do that—being the ever optimistic person, I was sure I would get the necessary people. I didn't get them, and consequently I had to break that promise, and I think as a result that program did not work very well.

Mr. ROGERS Thank you.

Your testimony has been most helpful. I may have some written questions to submit to you and if you will answer them for the record it would be appreciated.

Thank you for your presence today.

Dr. CHAFETZ. Thank you, sir.

[The following letter was submitted for the record:]

JOHNS HOPKINS UNIVERSITY,
CENTER FOR METROPOLITAN PLANNING AND RESEARCH,
Baltimore, Md., January 20, 1976.

Hon. PAUL ROGERS,
Chairman, Subcommittee on Health and the Environment, Interstate and Foreign Commerce Committee, U.S. House of Representatives, Washington, D.C.

DEAR PAUL: Thank you again for the invitation and opportunity to testify before your committee. You know how much I enjoyed it.

I think, however, there needs to be further elaboration on the outcome measures and findings that I discussed before the committee since the issue is so tinged by both emotionalism and stereotyping. This study, which will shortly be released, was done under contract by the Stanford Research Institute and the Rand Cor-

poration whose scientific credentials do not need my defense. Their findings blow out the water the accepted conclusion that if an alcoholic person, during recovery, takes alcohol, full relapse is inevitable. The goal of measuring successful treatment outcome of total abstinence for the rest of one's life has contributed to negative impacts: (1) it has set an unbelievably high standard for treatment outcome which terrifies many people from asking for treatment; and (2) it contributes to the therapeutic nihilism which has frustrated this field for far too long in spite of the findings which I shared with your committee.

I would still advise that a severely alcoholic person, recovering from the illness, *not* take alcohol and not risk finding out whether or not they could, in fact, drink socially. As I said in the introduction to *Alcohol and Health*, Volume 1, "The very fact that this report highlights *new* scientific findings warrants a word of caution. Scientific advances are made in discreet steps, each of which must be duplicated and repeated many times before we are certain that it is valid, how it should be interpreted and when it may be used. As we respect the rights of people to make their own interpretations and decisions and to accept their own risks based on the best available knowledge, it is ethical, imperative, to caution here about the limitations of applying broad findings on statistical populations to specific decisions by individals. Scientific truths concerning a population represented by a statistical average may be inapplicable or even invalid for many individuals within that population."

The unfortunate factor that your committee must always face in evaluating research findings is that because alcohol's use and abuse are ubiquitous, everyone has experience with those two phenomena and thereby they have developed preconceived, set notions. Most research and people's experience is based on what we call the individual servings as his own control. In other words, we take a slice of an individual's reality, introduce treatment or an event, and when there is a pre-post-change in that individual conclude that the treatment or event are responsible for this. Using this common research methodology, I once thought I was in line for a Nobel Prize. I had the pre- and post-treatment arrest records for a large number of patients kept independently of the program by the state police of Massachusetts and found that after these people had enjoyed my treatment program, their arrest record statistically and significantly dropped. It was a heriоc finding. Unfortunately, Paul, at the same time as I collected the people I treated, I collected comparison groups of people who did not receive my treatment but whose arrest records at the end of the study period had similarly significantly diminished to that of my patient population. In other words, when pre- and post-experience measures are used, the community and science may deceive themselves.

On the other hand, we do not say to the congestive heart disease patient or the diabetic, "If you take salt or sugar or show the evidence of relapse by fluid in your tissues or an increased sugar in your urine or blood, you have not recovered." We do not hold out for them the absolute necessity that we will not consider it a recovery unless their status is perfect for the rest of their lives. Therefore, our treatment attitudes toward heart disease and diabetic patients gives us satisfaction and hope. Even for dreaded malignancy, the surgeons give themselves a five-year rate to measure cure but this os not afforded to the person sick with alcoholism. I suspect that, although people view themselves as recovered and not reformed, when they judge others who are still ill, they behave as reformers rather than as helpers. The unfortunate impediment to the marvelous work of your committee is that we have forgotten that the Bible states that man was created in the image of God but that too many well-meaning people try to take their own personal experience and attempt to make the less fortunate over in *their* own image. Individual experience is essential in the development of our values for ourselves. They should have little or no value in developing national programs and priorities for other human beings.

I am taking the liberty of sharing this letter with some others. You know that I am available to you and your committee in any way you feel I may be of help. You have my best wishes.

Sincerely,

MORRIS E. CHAFETZ, M.D.,
Principal Research Scientist.

[The following questions and answers were received for the record:]

QUESTIONS SUBMITTED BY CHAIRMAN ROGERS AND DR. CHAFETZ'S ANSWERS

Question. If you as Director of the Alcohol Institute thought the Alcohol Act should be amended—

(a) What would you have to do?

(b) What would be your chances of getting such an amendment through OMB?

Answer. (a) Once a year a request is made by DHEW for legislative suggestions from its programs. If, as Director, I thought the Alcohol Act needed to be amended, we would prepare the suggested amendments and forward them to the Administrator of ADAMHA. After ADAMHA has massaged the language and examined the intent of the legislative proposals, the proposed amendments are returned to the Institute or forwarded to the Assistant Secretary of Health. If ADAMHA cannot support the legislation and refuses to send it forward, I, as the Director, have the right of appeal to the Administrator of ADAMHA. On the other hand, if ADAHMA supports the legislative intent, the amendments go forward with their supporting statements and interpretations. At the Assistant Secretary of Health's level, further massaging of the language and the implications of intent are stated. And if this office supports the proposed amendments, coordination with the legislative office of the Secretary of HEW is brought about. If all of this meets with the Department's approval, then the acquiescence of OMB is sought.

(b) The chances of getting an Alcohol Act amendment through the OMB are nil. OMB, if it believes that an amendment will require funding or contains the mechanism to create a funding momentum, will oppose and kill a legislative request. Since in the eyes of the AMB, any legislative request by a program must contain a funding implication hidden somewhere within the amendment, programmatic hope of getting OMB approval is poor.

Question 2. Describe the process by which the budget for alcohol programs is developed.

Answer. In preparation for the Presidential budgetary fiscal year exercise, the alcohol program is asked to develop a budget within fixed budgetary constraints. During by tenure as Director, the program was never asked what its perceptions and needs for a budget would be necessary to fulfill programmatic objectives. We were always placed in a budgetary straight-jacket and then asked our opinion of how we might intelligently wiggle to fulfill the devasting needs of alcoholic people. During my tenure at no time were the appropriations at all commensurate with the authorization levels. At no time did the Department and Presidential budget request for alcoholism go much beyond a continuation level for support already committed. In short, legislative and budgetary input for the alcoholism program were always devised *without* consideration of the input of NIAAA's leadership which is in stark contrast to the Congressional intent expressed in 91–616 which directed that the implemented power for the federal alcoholism program pass directly from the Secretary of HEW to the Director of NIAAA.

Question 3. In 1972, Congress established a special White House office to combat drug abuse. A White Paper prepared by the Domestic Council recommends continuing this focus—albeit without legislative authority. Should a similar office be established for alcohol problems or do you feel NIAAA is in a position to coordinate a Federal effort?

Answer. The White Paper prepared by the Domestic Council avoided the issue of alcoholism as the nation's number one drug problem. For consistency's and reality's sake, I believe that a special White House office to combat drug abuse demands a similar office for alcohol abuse. I believe that NIAAA is no longer in a position to coordinate the total federal alcoholism effort because the Inter-agency Coordinating Council called for in the 1974 Comprehensive Alcohol Abuse and Alcoholism Treatment, Prevention, and Rehabilitation amendments have not been satisfactorily implemented and because the many layers and impediments of bureaucratic processes of DHEW make the Institute impotent in carrying out its coordinating functions.

Question 4. Are there special problems of Indians who abuse alcohol? Should monies be earmarked for Indian programs?

Answer. There are indeed very special problems of Indians who abuse alcohol. The Indian people of this nation have twice the incidence of alcoholism and these alcohol problems are associated with three out of four of all social, health, and crime problems that plague the American Indian. Alcohol problems of the Indians are not the result of a genetic inability to metabolize alcohol. Studies affirm that they metabolize alcohol at the same rate as all other ethnic groups. Their serious alcohol problems are a consequence of the devastating outcome alcohol has on any person who suffers extensive physical, psychological, and social deprivation. Intensive deprivation produces unusual and dramatic response to alcohol intake for people so deprived. This committee does not need

my testimony to remind us how the American Indian has been deprived of everything that is worthwhile to a human being. Indian people must be responsible for examining, evaluating, and running their own Indian alcoholism programs. There should be a definite ear-marking of monies for Indian alcoholism programs.

Question 6. Do we know how many treatment slots there are versus how many we need?

Answer. The treatment slot concept, so useful to the other drug programs which contain more standardized therapeutic approaches, is not applicable to the treatment needs of alcoholic people. Study after study have affirmed that treatment approaches tailored to the needs of the individuals rather than to that of the program have high success rates. Treatment slots are in the direction of standardized treatment approaches and are antithetical to our knowledge of treatment needs of alcoholic people.

Question 7. Could you give us recommendations with respect to the need for credentialing of alcoholism counsellors?

Answer. The need for credentialing of alcoholism counselors has lost, in my opinion, its original intent. The field of alcoholism has many devoted and effective counselors whose dedication, compassion, and understanding are treatment essentials not easily credentialed. During my tenure. I reluctantly agreed to create the mechanism by which credentialing at the state level could be effected, only to open up the mechanism for the alcoholic population to receive their fair share of third party payments. It was in effect a trade-off on one hand against a certain amount of destruction of dedication, which is historically a well-known outcome of the credentialing process, in order to open up avenues of financing. What has occurred, however, is that many individuals concerned with the credentialing issue have economic and prestige motives to pressure the NIAAA to spend tax-payers dollars in creating a National Credentialing Organization. I was and am strongly opposed to this position. As a physician, I am a diplomate of the National Board of Medical Examiners.

But each state maintains its own right to license me to practice in that state and no third party that I know of pays out for services on anything other than state credentialing and not in response to national credentialing. We must bear in mind that many observers have lauded the People's Republic of China for their great contribution to the health delivery system in the fact that they emphasize performance criteria rather than credential criteria. Credentialing, in fact, only serves to create elitism. Credentialing does not help people lessen their suffering and function better. In my opinion, the whole issue of credentialing and the immature territorial battles raging around it are but manifestations that the alcohol movement has lost its original direction.

Question 8. Do states need single state agencies that deal only with alcohol programs?

Answer. I believe that some states will continue to require a single state agency whereas in other states the alcohol abuse program may be combined with other drug abuse programs.

Mr. ROGERS. The next witnesses will form a panel. We have a most distinguished panel, and the panel chairman, Mr. Mike Gorman, is an old friend of the committee. He is director of the Public Policy Office, National Council on Alcoholism. It is my understanding you have with you Mr. Fred Davis, Association of Half-Way Houses, Alcoholism Programs of North America; Maj. Ernest A. Miller, director of the National Public Affairs Office, the Salvation Army; Matthew Rose, executive director of the National Association of Alcoholism Counselors and Trainers; Dr. John Wolfe of the National Council of Community Mental Health Centers; Dr. Charles S. Lieber, of the American Medical Society on Alcoholism, Veterans Hospital; Dr. Richard Driver, associate director, Rutgers Center of Alcohol Studies; Lt. Col. Harry Smith, Volunteers of America; and Juanita Palmer, chairwoman, National Nurses Society on Alcoholism.

We welcome all of you and, Mr. Gorman, you might want to identify each or let each person identify himself for the reporter.

STATEMENTS OF MIKE GORMAN (PANEL CHAIRMAN), DIRECTOR, PUBLIC POLICY OFFICE, NATIONAL COUNCIL ON ALCOHOLISM; JUANITA PALMER, CHAIRMAN, NATIONAL NURSES SOCIETY ON ALCOHOLISM; MAJ. ERNEST A. MILLER, DIRECTOR, NATIONAL PUBLIC AFFAIRS OFFICE, THE SALVATION ARMY; JOHN CARPENTER, SENIOR DIRECTOR, RUTGERS CENTER OF ALCOHOL STUDIES, RUTGERS UNIVERSITY; LT. COL. HARRY SMITH, VOLUNTEERS OF AMERICA; MATTHEW ROSE, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF ALCOHOLISM COUNSELORS AND TRAINERS; FRED DAVIS, ASSOCIATION OF HALF-WAY HOUSES ALCOHOLISM PROGRAMS OF NORTH AMERICA; AND JOHN WOLFE, PH. D., EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS

Mr. GORMAN. Yes. I will have each person identify himself or herself for the record.

Mr. ROGERS. Fine.

Miss PALMER. Juanita Palmer, National Nurses Society on Alcoholism.

Mr. MILLER. I am Major Miller, with the Salvation Army.

Mr. CARPENTER. I am John Carpenter, senior director of Rutgers Center of Alcohol Studies.

Mr. SMITH. I am Lt. Col. Harry Smith, Volunteers of America.

Mr. ROSE. Matthew Rose, director of the Association of Alcoholism Counselors and Trainers.

Mr. DAVIS. Fred Davis, Association of Half-Way Houses of North America.

Mr. WOLFE. John Wolfe of the National Council of Community Mental Health Centers.

Mr. ROGERS. We welcome you to the committee, all of you, and any statements you have will be made a part of the record, and you may proceed as you desire.

Mr. GORMAN. Yes, sir. Thank you, Mr. Chairman.

I have a very brief statement and then I think I would throw this open to the committee members and the panel.

Very briefly, because of the limitations of time, I want to describe in 2 minutes what they are doing, why they are here in the field of alcoholism.

Mr. ROGERS. That would be helpful.

Mr. GORMAN. I do not want to make any lengthy comments on what Dr. Chafetz said previously.

I appeared here in 1973 before this distinguished committee, before Mr. Rogers, who is still the chairman, thank goodness, and Dr. Chafetz just slides off a statement that the committee ought to reconsider the conventional wisdom of having a separate program for drugs and a separate program for the drug alcohol. Now, he just lets that go without any documentation.

We are here to testify on the alcoholism bill, and in 1973 we fought that administration proposal of combining three institutes into one bag of worms, which was rejected by this committee. Three institutes had their own strong individual identity and responsibilities, and that you will remember we argued about. We do not say drugs are not an

important problem. We say each of the three, with all due respect to Dr. Chafetz, has responsibilities peculiar to it.

Then, the other statement that he did make, and I will go into my statement because I do not think this is the point at which to debate various points of view, except I do not think they ought to go by the committee without some question, and we have several distinguished gentlemen on this panel who have had a great deal of experience with alcoholism.

There is a statement on page 10 of Dr. Chafetz's statement where he says: "there is no guarantee in alcoholism recovery as to who will relapse and who will not," and that is very true, "a finding in this study reveals that relapse rates for those who go back to normal drinking in the recovery period are no higher than those who are long-term abstainers." We find no evidence for that.

In fact, the only scientific study that the National Council on Alcoholism has seen is that if one recovers from alcoholism and becomes dry, then goes back to drinking, that is the end of him, he eventually becomes an alcoholic again. That is a study by John Ewing of the University of North Carolina, a very distinguished scientist, Mr. Hefner, and a man who has spent many, many years in the field of alcoholism.

So I just want to raise a question—I am not going to make a debate on it, I want to raise a question. You say OK, this guy has recovered and he can have just one or two drinks, you know, and all right—one, two, becomes three, four, five, six—boom. He is back in business again. That is Ewing's study, and I do not know what study Dr. Chafetz is referring to, except that he has been up thinking at Johns Hopkins, and maybe they thought this up.

Mr. CARTER. On that very thing, I am in agreement with Mr. Gorman. I believe that if an alcoholic takes one drink he does endanger himself greatly, and probably will relapse.

In fact, I had a friend who was an alcoholic. I had helped him stop drinking but he went into delirium tremens when he was at home, and so he came to my home. He told me that as he was lying in bed he saw "Little Daddy"—who was his brother-in-law who had passed away a few years before—and said "Little Daddy" had his white hat on; and when he waved that hat, he knew it was time for him to go. So he got up and got in his car and he said, "On my way here, Doctor, I picked up Pectoral,"—I did not know who Pectoral was, but he said "little children started jumping under the car as I came to your house." "I did not want to run over them, Doctor, but," he said, "Pectoral could not see a one of them."

And when he came in, of course, one thing which will relieve them temporarily when they are in such a state is to give them a drink. I did not have one at hand, but I told him if he would take a drink that all these things he had imagined would disappear. But the unfortunate thing about it was that he took one drink and he never stopped. He died of cirrhosis of the liver.

Thank you, Mr. Gorman.

Mr. GORMAN. This is the whole point, Dr. Carter, stated much better than I. Being a medical doctor, you know one drink is too many and then a thousand are not enough. One drink is too many.

Mr. CARTER. Yes, sir.

Mr. GORMAN. Mr. Chairman, I really want to express on behalf of this panel, this very diverse panel, the deepest gratitude of all organizations in the alcoholism field, and related to alcoholism, to the chairman for his introduction of H.R. 11317 before the recess, and for his prompt scheduling of the hearings today.

As we understand, the legislation before us extends for 3 years without any increase in authorization Public Law 93–282, which passed the House in 1974 by an overwhelming bipartisan vote of 301 to 17, a very close vote.

As you no doubt remember, Mr. Chairman, when we testified on Public Law 93–282 late in 1973 before this very committee, we were not arguing the point about the divisibility of institutes, clear indications that each institute must do its own job without a big bureaucracy on top. We appeared as a panel and, as you know and Dr. Chafetz has mentioned it, we had at that time great support from not only the alcoholism organizations per se but from organizations like the National Association of County Officials and the American Medical Society on Alcoholism, AFL–CIO, and the education commission of the States, a very distinguished organization, and the National Congress of Parents and Teachers, and so on.

We knew then we were trying to build up the public's interest in this problem, and it relates somewhat to some of Mr. Hefner's questions about always having a drink on TV and that kind of thing, and these are the organizations that are around this table that are now going to question that, you know, counteracting such practices that as your hostess opens the door she does not take your coat off, she hands you a drink and then takes your coat off. It is a little difficult, especially if she is a very nice hostess.

Now, in a prior appearance before the other body that same year, that is in 1973, Mr. Chairman, we testified for a higher, authorization than contained in the present bill because we had completed a survey of applications for alcoholism project grants at the grassroots which indicated more money was needed to stimulate the operation of alcoholism treatment facilities in the heart of the community.

For us, as citizens, that was the name of the game, not a big bureaucracy but active treatment facilities right in the local community.

As you know, the other body adopted our recommendations for project grants at a level of $100 million for fiscal year 1975 and $110 million for fiscal year 1976, which is the year we are still in.

In the conference between the two bodies this project grants authorization was reduced to $80 million for fiscal year 1975 and $95 million for the current fiscal year.

Naturally, we would have liked the higher authorizations because we knew they were needed, but we are pragmatists and we understand the necessity for some temporary belt tightening in light of the present economic situation, and the present bill merely extends those authorizations that were finally adopted in 1974.

We are particularly pleased with the inclusion in H.R. 11317, Mr. Chairman, of the special grants for implementation of the uniform alcoholism treatment act.

Approximately one-half of our States—whether it is 25 or 27—have decriminalized alcoholism over the past several years. In essence, it is no longer a crime because we find you drunk. But many localities lack finances to provide treatment facilities which are alternatives to the

barbaric jailing of alcoholics, and that is true even here in the District where we passed the first Decriminalization Act in 1967.

It is rhetoric. If you do not have some place to put them there is no point in passing a decriminalization act, having no treatment facilities available for alcoholics. Unfortunately, in a number of States, this condition still exists, and that is an understatement, and the alcoholic who was formerly thrown into jail, he cannot be now if there is a decriminalization act; he now finds himself out on the street. That is simple, it is just that simple, he finds himself out on the street, and they would rather go back into the jail—it is warm, they have heat, some place, but he is out on the street now because the alcoholic has been decriminalized but there are no alternative treatment places where he can go.

There is not a half-way house, there is nowhere where he can go and be taken care of. We could make a number of suggestions as to the contents of the bill. We are not going to do it. I could make 150, Mr. Chairman, but I am not going to make any of those because H.R. 11317 is a darn good bill. But we know that we have a time constraint, too.

In the House Appropriations Committee, Chairman George Mahon of the great State of Texas has announced all appropriations committees must complete hearings by April 14, 1976. He made that statement in the record in early December of last year. Since we do not have an authorization for fiscal year 1977 and beyond, in other words, we are only authorized up to June 30, we are absolutely up, we are, therefore, foregoing any suggestions for major alterations of the legislation.

Furthermore, we think it is a darn good bill. However, we suggest one small amendment which is of vital importance to the smaller States, and you gentlemen can consider it and say, well, if it is going to hold up, the passage of the bill, we will say okay, we give in. At the present time, the minimum amount for a formula grant to each State is $200,000. Now these formula grants go out to the various States, as you know, and the States use them to set up their own alcoholic programs.

Our studies have indicated that $200,000 is too low in many of the smaller States, and we suggest respectfully that the minimum formula grant which goes to the State authority be raised to $300,000. This would not involve any increase in the total amount contained in H.R. 11317. It would merely involve a small reallocation of these formula grants between the large States and the small States. That is all we are asking. The sum would still be the same, but it would be reallocated on the basis of $300,000 for each small State.

Because of the pressures of time, we cannot at this juncture give the full report we would like to on the remarkable progress that the National Institute for Alcoholism Abuse and Alcoholism has made against a disease which heretofore was neglected for close to two centuries in this country.

Dr. Chafetz has done a very fine job of pointing out many of the areas that I have touched upon, and we are a baby institute when you compare us with cancer and heart. And the chairman knows I have been in the cancer battle and heart battle and any battle about health I could get into. But we are a new institute; we are 5 years old and we are just beginning to grow, but I contend and say this in my statement and I hold with it: In a general way we contend in the short period

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of 5 years since its inception the National Institute of Alcoholism has made greater progress against this disease than that of any other institute in HEW in comparable endeavors against their categorical disease responsibilities.

I am very careful when I say that but I have been in this town for 25 years, and I have watched the slow growth of these various institutes up to the point where cancer is rightfully, I think, at a $743 million figure, and heart is up to $360 million, and we are down there among the lower ones moving up.

But we have made an awful lot of progress and I think an awful lot of impact upon the American people which is, I think, the most important thing that we have been able to do, the National Institute has been able to do, and the voluntary organizations around this table, too.

We have one major caveat. Dr. Chafetz generally has dealt with that very, very well, as has the chairman in his questioning of it. We believe that the National Institute must devote more of its funds to prevention and education. We have studies indicating a frightening rise in teenage alcoholism down to the elementary schools. You can go, and I have gone out into the District of Columbia schools and counted the bottles, all kinds of pop, wine and stuff. During the recesses they bring it to school, kids in the junior high school and senior high school bring alcohol, and I mean hard alcohol, not only beer to school with them in their lunch baskets. I want to be just as tough as the next guy, too, my lunch basket has a pint of gin in it and we are seeing an awful lot of that, and I think the National Institute will publish shortly—I have been informed—a massive study of this rise in teenage alcoholism.

The kids are really boozing it up, and they are the ones that do the late night drinking and they are the ones that go screaming down the highways at 70 miles an hour. They are really a menace, and they worry me. They worry me, this trend toward alcoholism among our youth.

Now, last year the HEW released the first followup of alcoholics treated in alcoholism treatment centers which you and the Congress funded, and generally I think previous testimony has dealt with this. The study was done by the highly prestigious Stanford Research Institute of California.

A major conclusion of the study showed that 70 percent of the individuals treated in these alcoholism centers showed a remarkable reduction in alcoholic intake, and Dr. Chafetz has gone into that problem because it was during his 5-year tenure as Director of the National Institute on Alcohol Abuse and Alcoholism that this study was done and completed.

As a result of your constant legislative support, the National Institute of Alcoholism has made sensational progress in an area which was once thought hopeless—heavy drinking among American Indians and Alaskan Natives.

I have that in my prepared statement and I will skip over it and, if I may, include it in the statement that we have. I know that in 5 years' work on a newspaper in Oklahoma I talked about Indian alcoholism. They would say, "All Indians are drunks because they are Indians and what are you sweating about that problem for?" I said, "Well, I am just curious. I think I have got a vein of curiosity in me as to why this heavy drinking among the Indian alcoholic, and nothing is being

done about them because nothing was done about the white alcoholic either."

In those days, the Indian alcoholic was prevalent. Contrary to popular impressions of people from States like Nevada, elsewhere—Oklahoma has more Indians than any State in the United States, that is a fact, nonreservation Indians. So you saw many of them, and you saw many Indian drunks.

Now, just two more points and I will conclude my statement, Mr. Chairman. Maybe the panelists will either respond to questions from you, or maybe give a one or two-minute précis of their point of view.

Along with the growth of—first of all, I want to deal with labor and management, and the panel before this session today was supposed to be chaired by Leo Perlis of the AFL–CIO, chairman of our new committee which we formed among a massive list of organizations, and appended to my statement, "The National Coalition for Adequate Alcoholism Programs," and includes every organization from A to Z and back to A that we asked—and it is very heartening that in the first meeting we held in December 1975, because we had just begun this activity, we invited 21 organizations. We received acceptances from 19, and the other two said they would take it back to their boards for joining.

We hope eventually to have a couple of hundred organizations in this National Coalition for Adequate Alcoholism Programs. But I think one thing that we at the NCA are very proud of, and we work closely with the National Institute on this, but we have done a lot of work on our own since 1964 on it—we have established a powerful labor-management department working closely with industry and labor to establish alcoholism treatment programs in hundreds of industrial plants across the land.

It is many times the worker who must be detected, who denies that he is a drinker, but never comes into work on Monday. He has an accident rate three or four times higher than the guy next to him, and it is a very tough problem of getting to him.

We are getting to him more and more, and when I say the worker I must also include the corporate executive, because he also drinks his share, too. He also drinks his share and he has his share of denial, too.

Now, under a grant from the National Institute we are establishing both labor and management alcoholism programs in 10 major cities, as a start to go to industry in these various places to talk to management and talk to labor and say why don't you set up an alcoholism treatment program. If you approximate the average in the country, you have got from 10 to 20 percent of your people who are alcoholics, and I do not mean moderate ones, social drinkers who take a sherry before they go on the assembly line, or take a sherry before a corporate board meeting. I mean people who really drink heavily, who are alcoholics.

Along with the growth of teenage alcoholism, as I have said before, Mr. Chairman, we have established a strong department of prevention and education. Again, it is a beginning, but I say it is a strong department in the NCA, which is working closely with the schools, with families and with community leaders to get a hold on this problem.

and it is going to take everybody. We cannot do this one alone. The schools cannot do this alone.

I have talked with school principals who say "I know there are bottles out there, but how about the family, how about the community—somebody has to help us in preventing this epidemic thing." So that is a big problem.

Our third problem, as Dr. Chafetz dealt with, is that we are deeply concerned with the rise in the number of women alcoholics, and the figures are really staggering, as he told you. It is probably up to about one-third of all alcoholics, and these are people who are sick, they have the disease of alcoholism. They are not social drinkers, not the gal who drinks the sociable sherry or sociable something else, and here we are concentrating much of our limited resources—speaking of the National Council on Alcoholism, which is a private, voluntary organization—we are concentrating much of our limited resources on both State and National programs to bring this problem into the open, and bring it under control.

We recently established a Women's National Steering Committee which will advise, review and evaluate the findings and activities of the State voluntary task forces on women and alcoholism, which have been developed in about 20 States. We had a very successful conference in the State of New Jersey on this problem, largely spurred by Senator Williams, who is chairman of the Senate Labor and Public Welfare Committee, and deeply interested in alcoholism.

We do not deny, Mr. Chairman, that although there is a much greater acceptance today of the fact that the alcoholic is a sick person, the stigma of alcoholism is too prevalent in our society.

However, we are heartened by the fact that you, our elected officials, are in the forefront of the effort to wipe this unfair stigma from the face of this land.

In conclusion, Mr. Chairman, may I point to one new and exciting development which is a direct outgrowth of your confidence in us. On November 26, 1975—then I go into it, and I do not have to go into this again—the president of our organization invited these various other organizations—that is the 21 other organizations—to come to a meeting to find out how we could get a handle on many of the problems that I have dealt with, and in conclusion we adopted several resolutions, and I have just one paragraph, the final paragraph—I do not have all the "whereases" because there were about 35 whereases.

We came down to this statement: "The undersigned submit to the Congress of the United States that the legislative mandate of the National Institute on Alcohol Abuse and Alcoholism should be renewed and such funds be authorized and appropriated as may be necessary for it to continue its vital leadership role in the prevention, control, and treatment of alcohol abuse and alcoholism, and the rehabilitation of affected individuals."

Thank you, sir.

[Mr. Gorman's prepared statement follows:]

STATEMENT OF MIKE GORMAN, PANEL CHAIRMAN, DIRECTOR OF PUBLIC POLICY OFFICE, NATIONAL COUNCIL ON ALCOHOLISM

Mr. Chairman and members of the committee, first of all, we would like to express the deepest gratitude of all organizations in the alcoholism field to the Chairman for his introduction of H.R. 11317 before the recess and for his prompt scheduling of the hearings today.

As we understand it, the legislation before us extends three years—without any increase in authorizations—P.L. 93-282, which passed the House in 1974 by an overwhelming bi-partisan vote of 301 to 17.

As you no doubt remember, Mr. Chairman, when we testified on P.L. 93-282 late in 1973, we appeared as a panel which included a number of organizations among which were:

National Council on Alcoholism;
Alcohol and Drug Problems Association of North America;
U.S. Jayces Foundation;
National Association of County Officials;
Association of Labor-Management Administrators and Consultants on Alcoholism;
American Medical Society on Alcoholism;
AFL-CIO;
United Auto Workers International;
Education Commission of the States;
Council of State Alcoholism Program Directors;
American Indian Commission on Alcoholism;
Association of Half-Way Alcoholism Programs of North America; and
National Congress of Parents and Teachers.

In a prior appearance before the other body that same year, we testified for higher authorizations than contained in the present bill because we had completed a survey of applications for alcoholism project grants at the grass roots which indicated that more money was needed to stimulate the operation of local alcoholism treatment facilities in the heart of the community.

As you know, the other body adopted our recommendations for project grants at a level of $100 million for Fiscal 1975 and $110 million for Fiscal 1976. In the Conference between the two bodies, this authorization was reduced to $80 million for Fiscal 1975 and $95 million for the current Fiscal year. Naturally, we would like higher authorizations, because we know they are needed, but we are pragmatists and we understand the necessity for some temporary belt-tightening in light of the present economic situation.

We are particularly pleased with the inclusion in H.R. 11317 of the special grants for implementation of the Uniform Alcoholism and Intoxication Treatment Act. Approximately one-half of our states have decriminalized alcoholism over the past several years, but they lack the finances to provide treatment facilities which are alternatives to the barbaric jailing of alcoholics. There is no point in passing a decriminalization act and then having no treatment facility available for the alcoholic. Unfortunately, in a number of states this condition exists, and the alcoholic who was formerly thrown into jail now finds himself out on the street.

We could make a number of suggestions as to the contents of the bill, but we know that we have a time constraint in that House Appropriations Committee Chairman George Mahon has annnounced that all appropriations committees must complete hearings by April 14, 1976. Since we do not have an authorization for Fiscal 1977 and beyond, we are therefore foregoing any suggestions for major alteration of the legislation.

However, we suggest one small amendment which is of vital importance to the smaller states. At the present time, the minimum amount for a formula grant is $200,000. Our studies have indicated that this is too low, and we suggest that the minimum formula grant which goes to the state authority be raised to $300,000. Mr. Chairman, this would not involve any increase in the total amount contained in H.R. 11317—it would merely involve a minor reallocation of these formula grants between the large states and the small states.

Because of the pressures of time, we cannot at this juncture give the full report we would like to on the remarkable progress that the National Institute on Alcohol Abuse and Alcoholism has made against a disease which heretofore was neglected for close to two centuries in this country. In a general way, we contend that in the short period of five years since its inception the NIAAA has made greater progress against this disease than that of any other Institute in HEW in comparable endeavors against their categorical disease responsibilities. We have but one major caveat—we believe that the NIAAA must devote more of its funds to prevention and education. Late last year, HEW released the first follow-up study of alcoholics treated in the Alcoholism Treatment Centers which you in the Congress funded. The study was done by the highly prestigious Stanford Research Institute. A major conclusion of the study showed

that 70 percent of individuals treated in these Alcoholic Centers showed a remarkable reduction in alcoholic intake—including a high percentage which in certain categories achieved total abstention. The number of individuals totally abstaining in the last month of the year was 46 percent, an increase from 12 percent when the survey began some two years before.

As a result of your constant legislative support, the NIAAA has made sensatitonal progress in an area which was once thought helpless—heavy drinking among American Indians and Alaskan natives. We are all familiar with the stereotype that practically all Indians are drunks, that they cannot hold their liquor and that, therefore, it is hopeless to put them into any kind of treatment program. With your support, the NIAAA has conducted a modest program in this area since its inception. A 1975 evaluation of this program points up some remarkable results:

Fifty percent of Indian alcoholism program clients recover and become productive citizens.

Approximately 20 percent get jobs through the program. This is especially important with exceedingly high rates of Indian unemployment.

Most remarkable, approximately 100 Indian Alcoholics Anonymous groups have been established in the past three years—an almost unbelievable achievement. One must realize that there were no AA groups among our Indian population prior to the establishment of the Alcoholism Institute.

The Stanford Research Institute study also reported equally dramatic and comparable success in the Institute's programs in labor and management, in its work with drunken drivers and in too many other areas to report here.

This is not to say, Mr. Chairman, that the challenges before us are not tremendous. Over the past few years at the NCA we have established a powerful Labor-Management Department working closely with industry and labor to establish alcoholism treatment programs in hundreds of industrial plants all across this land. Many of these programs are restoring 60 to 70 percent of valued workers to productivity again. Under a NIAAA grant, we are establishing both labor and management alcoholism programs in ten major cities. Alarmed at the growth of teen-age alcoholism, we have established a strong department of prevention and education which is working closely with the schools, with families and with community leaders to get a hold on this problem. We are deeply concerned with the rise in the number of women alcoholics, and here again we are concentrating much of our limited resources on both state and national programs to bring this problem into the open and to bring it under control. The National Council on Alcoholism has recently established a Women's National Steering Committee which will advise, review and evaluate the findings and activities of the state voluntary task forces on women and alcoholism which have been developed in about 20 states. We do not deny that, although there is much greater acceptance today of the fact that the alcoholic is a sick person, the stigma of alcoholism is still too prevalent in our society. However, we are heartened by the fact that you, our elected officials, are in the forefront of the effort to wipe this unfair stigma from the face of this land.

In conclusion, Mr. Chairman, may I point to one new and exciting development which is a direct outgrowth of your confidence in us. On November 26, 1975, John K. MacIver, President of the National Council on Alcoholism, wrote to a number of organizations directly or indirectly related to the problem of alcoholism asking them to join a new coalition for adequate alcoholism programs. We had no idea what kind of response we would receive. To our utter amazement, when we held our first meeting on December 11, 1975, nineteen of the twenty-one national organizations who had been invited sent their top representatives for that historic meeting at the AFL–CIO Building here in Washington. They represented millions of members from the AFL–CIO, the Salvation Army, the Volunteers of America, the National Nurses' Society on Alcoholism and many more. They journeyed to the meeting from California, Colorado, Minnesota, Michigan, Louisiana, Georgia, and so on. We would like to include a list of the organizations represented at this initial meeting at this point.

A number of resolutions were adopted and we would just like to quote here the concluding paragraph of the basic resolution unanimously adopted by the members of the National Coalition for Adequate Alcoholism Programs:

The undersigned submit to the Congress of the United States that the legislative mandate of the National Institute on Alcohol Abuse and Alcoholism should be renewed and such funds be authorized and appropriated as may be necessary for it to continue its vital leadership role in the prevention, control, and treatment of alcohol abuse and alcoholism and the rehabilitation of affected individuals.

NATIONAL COALITION FOR ADEQUATE ALCOHOLISM PROGRAMS

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Dr. Anthony Carpenter, Director, Rutgers Center of Alcohol Studies, Rutgers University, New Brunswick, N.J. 08903.

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Henry B. King, President, United States Brewers Association, 1750 K Street, N.W., Washington, D.C. 20006.

Col. Ray C. Tremont, Southern Regional Headquarters, Volunteers of America, Metairire Tower, 433 Metairire Road, Metairire, La. 70005.

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Jim Baxter, Executive Director, ALMACA, Suite 350 Park Plateau, 300 Wendell Court, Atlanta, Ga. 30336.

Malcolm Harris, President, Distilled Spirits Council of the US, 1300 Pennsylvania Bldg., Washington, D.C. 20004.

Matthew Rose, Executive Director, National Association of Alcoholism, Counselors & Trainers, P.O. Box 756, 2504 Curtis Road, Arlington, Va. 22201.

Mike Gorman (National Committee Against Mental Illness), NCA Public Policy Office, Suite 812, 1101 17th St., NW., Washington, D.C. 20036.

Dr. John Wolfe, National Council of Community Mental Health Centers, 1346 Connecticut Ave., N.W., Suite 931, Washington, D.C. 20036.

Juanita Palmer, Chairwoman, NNSA, 270 Brookwood Dr., Longmeadow, Mass. 01106.

George C. Dimas, Executive Director, National Council on Alcoholism, Inc., 2 Park Avenue, New York, N.Y. 10016.

David Vallo, Chairman, National Indian Board on Alcoholism & Drug Abuse, 2969 Fulton Avenue, Sacramento, Calif. 95821.

Mr. ROGERS. Thank you, sir.

Thank you very much for your statement in support of legislation to continue the program.

Now, I think we might go around the panel quickly, if we could. If each of you would point up for us the main problem you see, what you think needs to be done quickly, and comment as to whether we should simply give a block grant to the States and let the States do it, rather than maintaining a Federal program.

So, maybe we can have Miss Palmer lead off.

STATEMENT OF JUANITA PALMER

Miss PALMER. Because the nurses have such a free role in the treatment of all patients and in the area of prevention and in the area of education, case findings, treatment, rehabilitation—you name it, we have been some of the first people to recognize the need of the alcoholic in all these areas, not only the alcoholic but his family, his children, and have recognized before many others the need of funding to help others understand the alcoholic and his family.

So, therefore, we in these vital areas, not only in the health agencies but in the community where we work, we have begun trying to not only recognize our own role in the treatment and prevention and education in the field of alcoholism, but to help work with the community, the hospitals, and so forth, in this area.

I would say that because of the nurse and her unique or his unique role, whatever, that it is rather imperative that we take a stand and say that we have seen over the many years that because there was not the recognition that alcoholism was an illness, there was not proper treatment, and with the funding of the National Institute about 5 years ago, we can look back and say, gee, what a real change has been made in all areas.

We, therefore, say we just really are beginning but we have a long way to go, so we feel with the additional funding and with support of what we have that we will continue to grow and so, therefore, representing the Nurses Society on Alcoholism I would like to say we support the funding of this and any additional funding when appropriate.

STATEMENT OF MAJ. EARNEST A. MILLER

Mr. MILLER. I am Maj. Earnest Miller, the director of the National Public Affairs Office for the Salvation Army.

I represent an organization that has been active in the treatment of alcohol abuse for more than 100 years, with some considerable success in rehabilitating many thousands of lives. And our concern, of course, is for the individuals, the people who are the victims of alcohol abuse, and the families of those people.

Much of our poverty in this Nation and elsewhere in the world as well, can be traced to alcohol abuse, and perhaps the most acute victims are the children and the wives, and now the husbands of alcohol abusers.

We have been pleased that in recent years new legislation has made it possible for us to upgrade some of our alcohol abuse programs, that is, to combine with programs that were essentially voluntary programs, programs that were primarily the use of alcoholic counseling by alcoholics who were themselves rehabilitated. We have been able to combine with that some technical expertise and some study that was going on so we could upgrade the quality of our programs.

In addition to that, we have been able to cooperate with the courts and the local authorities in many communities to create programs that were cooperative and supportive of the public sector and private sector, thereby using the best resources of each, and we feel that the legislation that is to be the most desirable legislation that may be passed, or the most appropriate use of public funds would be to reenforce the proven methods of alcohol abuse and treatment which we believe is the use of alcoholics to counsel alcoholics.

We believe that the most effective counselors are those who have had experience of alcohol problems, and we believe public moneys should reenforce those programs, and we believe that the best direction is to multiply the effectiveness of all of the resources by combining public funds with private funds. That is, the donated funds of private citizens to organizations such as our own and those represented around this table, and adding to that the voluntary effort that can be added to the use of funds.

We do not believe that the best service, or all of the service ought to be bought and paid for. We believe that the use of volunteers—people who give their services and their efforts—can multiply the effectiveness of both private and public funds to good results.

We would like to see a continuation or expansion of those programs.

Mr. ROGERS. Thank you very much for an excellent statement.

Mr. MILLER. Thank you.

STATEMENT OF JOHN CARPENTER

Mr. CARPENTER. Mr. Chairman, my name is John Carpenter. I am director of the Center of Alcohol Studies at Rutgers, and I have been a full-time researcher since 1954 in this field. Now, my pitch is for research.

First, I would like to say we support this bill. My pitch is for research on the ground that research is cost effective. Before I go into that, I would like to say that we do not believe in supporting research at the expense of the other services and activities of the NIAAA. Those things are essential. For one reason, it is going to be awhile before research is successful.

Now, if research is successful, the cost of the services, including therapy, will no longer be necessary at least to this extent, and neither will the cost of research. And Dr. Chafetz does not like the infectious, acute infectious disease model, and it does not apply here in most senses, but it does in one sense. It is a model of scientific success and if you take a look at the history of polio you will see that the National Foundation for Infantile Paralysis had a life of about 25 to 30 years. It went out of existence as far as support of polio, went out of business when research was successful.

What I am suggesting is that the research branch of NIAAA can go out of business, too, once research has been successful.

Where is the money going to come from? It is not going to come from private sources. Private individuals think of research funds as welfare for scientists, and I think that without support from the Federal Government this is not going to come about.

[Mr. Carpenter's prepared statement follows:]

STATEMENT OF JOHN A. CARPENTER, PH.D., DIRECTOR, RUTGERS CENTER OF ALCOHOL STUDIES, RUTGERS UNIVERSITY

Mr. Chairman and Members of the Committee:

The Rutgers Center of Alcohol Studies supports H.R. 11317, the three year renewal of the Comprehensive Alcohol Abuse and Alcoholism Prevention and Rehabilitation Act of 1970.

We support and urge the renewal of the legislation which established a federal effort to deal with alcoholism and other alcohol problems.

The health and societal problems associated with the abusive consumption of beverage alcohol are expensive to the abuser, to the abuser's family, to the abuser's employer, to many people who come in contact with the abuser, and to our economy. The direct and indirect costs of alcohol abuse, estimated to be in the billions, is so great that only the federal government can respond adequately.

More important, alcohol problems waste human lives and human potential and lead to an immeasurable amount of physical and emotional suffering by the abuser and others. The exact number of alcoholics, problem drinkers and people affected by them is irrelevant—the fact is, it is a monumental problem which will not simply evaporate.

This Subcommittee and the Subcommittee on Alcoholism and Narcotics in the Senate recognized the responsibility of our government when it wrote the original legislation. The renewal of the legislation is necessary to prevent the country from slipping back to a response of avoidance.

The inroads and advances made by the National Institute on Alcohol Abuse and Alcoholism are important and, through the efforts of the Institute, a first response to the alcohol problems has been undertaken. But these efforts will have been wasted if the Institute cannot build on the foundation that has been set.

H.R. 11317 addresses an important segment of the health needs of this nation. The physical and emotional health of the nation is an essential component of a healthy economy.

Mr. Chairman and Members of the Committee, I want to thank you for allowing me to testify before you today. The Rutgers Center of Alcohol Studies is available to assist you and the staff of the Subcommittee.

Mr. ROGERS. Thank you very much.

Mr. HEFNER. Just briefly——

Mr. ROGERS. I was hoping we could let them all make a statement and then begin questions.

Mr. HEFNER. I yield to the chairman.

Mr. ROGERS. Colonel Smith?

STATEMENT OF LT. COL. HARRY SMITH

Mr. SMITH. I am Col. Harry Smith, from the Volunteers of America in Baltimore, and it was not until Friday I knew I was coming, and it was not until 20 minutes ago I knew I was going to say anything. But whatever I say is strictly from the top of my head.

The Volunteers of America, of course, is 80-years old this year and we are sincerely appreciative of the funding by the Government to help out with th alcoholic programs that we have in the country. We have been dealing with the alcoholics and homeless men since 1896, our inception, although we all know the alcoholic and homeless man has been with us since Middle Ages.

I would like to mention that in Baltimore we operate a 7-day emergency shelter program for the alcoholic after he has completed the detox center. From our program he then goes to either a quarterly, halfway house, or State hospital, and as I have said before, I did not know I was going to speak. The Volunteers of America is sincerely appreciative of all the funding the Government has been able to help this program with.

Mr. ROGERS. Thank you very much, Colonel, for your presence and comments.

STATEMENT OF MATTHEW ROSE

Mr. ROSE. My name is Matthew Rose, and I am the director of the National Association of Alcoholism Counselors, and I kind of agree with the lad who just spoke, but I think he is talking about a fairly narrow segment of the total treatment and recovery program that is essential for the successful operation of an alcoholism endeavor.

Our organization is a new one and we are trying to establish a new profession, and I think at the present time we have a constituency of about 3,000 or 4,000, and we are in all sorts of institutions from jails to hospitals to residential care organizations. I would like to see the day come when we could have a man capable of hanging a shingle outside of his house, and being an alcoholic counselor he would have a function of referring to the more appropriate resources, and to carry a man into a program of recovery such as Alcoholics Anonymous where he would have an opportnuity and fair shake at having an opportunity to live again.

I think that this legislation certainly should be authorized as soon as possible to maintain the program we have got going, but to be successful in this thing, I think we have to tap into the regular health care system, including third party payment, and we are right on the edge of it right now, and a little more and a little more cooperative effort on the Federal agencies and the programing direction in this area would open the resources in the nature of $1 or $2 billion, which really is the kind of money that is necessary if any dent is going to be made in the problem of alcoholism.

Thank you.

Mr. ROGERS. Thank you so much for your statement.

Mr. Davis?

STATEMENT OF FRED DAVIS

Mr. DAVIS. Thank you, Mr. Chairman.

Mr. Chairman, I am repersenting the Half-Way Houses Association of North America and, as you know, we have advocated the establishment of halfway houses in our country. We support the passage of H.R. 11317, the reason being that we have had the opportunity to work very closely with the Institute.

With the kind of Federal dollars that have been put in the halfway house movement, it has made for a better halfway house situation and that we are now being able to change commuity attitudes about the acceptance of halfway houses in their community. We are now getting halfway houses in better communities and there is now becoming a dividing line between a halfway house and a flophouse.

For that reason and for reasons of the lack of funds on the local level, we support this bill and we support the kinds of attitudes that the Institute has taken, and the kind of effort that they have provided in this movement.

Thank you very much.

STATEMENT OF JOHN WOLFE

Mr. WOLFE. Mr. Chairman, we have submitted a statement for the record. I would like to answer the question that you asked with regard to the State block grants.

I think that such a move would be a disaster for the field of alcoholism as well as for categorical programs, and just in brief, I think it is incumbent upon all of us to really consider and think of new ways whereby not only the Federal Government but also the State governments and local governments can join together in funding rather than this either/or kind of situation that we find ourselves in continually. And I think until we can come to grips with that kind of question we are always going to be faced with severe financial problems.

[Mr. Wolfe's prepared statement follows:]

STATEMENT OF JOHN WOLFE, PH.D., EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS

This statement is presented on behalf of the National Council of Community Mental Health Centers (NCCMHC) representing 337 community mental health centers, most of which receive federal funding under the Community Mental Health Centers Act, and another 138 agencies which are developing CMHC programs or which have a direct interest in community mental health. This statement addressses the need for additional authorizations for programs of assistance in the area of alcoholism and alcohol abuse.

NCCMHC supports the extension of authorizations through fiscal year 1979 for alcohol programs under the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 which HR 11317 would accomplish.

Our principal reason for appearing before you today is to make sure the record shows that community mental health centers are viable vehicles for providing community based alcoholism services.

Preventive measures are the key to reduced societal costs of mental illness. Public Law 94-63 authorizes a new consultation and education grants program which will focus on preventive mental health services provided by community mental health centers. The Act also requires centers to insure the provision of specialized programs for alcoholism, which must also include preventive services, as well as treatment of alcohol abuse and alcoholism and rehabilitation of alcohol abusers and alcoholics where those needs are currently not being met. Community mental health centers which do not add the required services within two program years (not fiscal years) will lose all federal funding.

Alcoholism is a major disease at this time with an estimated 9 million victims. On a national basis approximately eight and one half percent of all CMHC admissions are individuals with alcoholic disorders.

H.R. 11317 would provide additional federal funds for which community mental health centers could apply thus enabling them to meet the requirements of Public Law 94-63. It is important that legislation authorizing community based alcoholism programs continue to recognize the community mental health center as an appropriate resource and facilitator in the delivery of such services.

We support the extension of authorizations for these vital programs at a level of funding at least equal to that in H.R. 11317. We urge the committee to move quickly since the legislation must be reported by May 15, 1976 under the Congressional Budget and Impoundment Control Act of 1974.

Mr. ROGERS. Thank you very much.

Dr. Carter?

Mr. CARTER. Yes, sir; I have some questions.

When is an alcoholic amenable to treatment?

Mr. GORMAN. When is he amenable to treatment?

Mr. CARTER. Yes. When can you treat him?

Mr. GORMAN. Well, not being an expert and being an M.D. and not having practiced in southern Kentucky, I am going to be very wary of that.

I wonder if Dr. Carpenter, or somebody else at this panel would answer?

Mr. CARPENTER. Not being a doctor from Kentucky, I cannot answer it either.

Mr. WOLFE. I would like to respond to that out of my experience.

I work as a clinician, and have worked as a clinician. I formerly was with the Institute of Alcohol Abuse and Alcoholism. In my practice I found different stages of alcoholism are always amenable to treatment. I found people that were in the very beginning stages, did not even know they had a problem, would not have been diagnosed that way medically, but who upon research through therapy and counseling were able to identify they were having difficulties with alcohol, marriage, job or whatever, and were amenable to treatment.

Mr. ROSE. In the counseling business we have noticed a real upsurge in the young people coming up, being picked up and sent to a program, and joins in with the AA fellowship and really enjoys life again, very successful, 16 and 17 years old.

Mr. CARTER. You have been able to help those youngsters?

Mr. ROSE. Yes, recovery.

Mr. CARTER. Fine. With older alcoholics, particularly, there once was a saying that one had to hit the bottom before he could come up. Do you agree with that?

Mr. ROSE. I think we all agree with that. Wherever you stop it is bad enough, or you would not stop.

Mr. DAVIS. I would like to say something else about that. I think that has been a copout, that you have to reach bottom before you can respond to treatment. I think that is a copout on the part of service providers. I think one of the responsibilities of service providers is if a bottom is needed to create a bottom, if we talk about combating alcoholism from the level of prevention to the level of chronic alcoholism, then we have to develop all kinds of expertise to intervene on these different kinds of levels.

Mr. CARTER. I feel idealistic, of course, since prevention is by far the better method. It is worth everything.

Mr. DAVIS. I would agree.

Mr. CARTER. But in my experience, once one becomes an alcoholic he is rather difficult to treat and cure.

Do you use antibuse now in the treatment of alcoholism?

Mr. WOLFE. Some people do, some do not.

Mr. CARTER. Have you found it very effective, Doctor?

Mr. WOLFE. I have not used it. I am a psychologist.

Mr. CARTER. You have not used it. Have any of you used it?

Mr. SMITH. Some of the people coming into our program are under the antibuse program at the hospital, and they will be using it. We have some that do take medication and some do not.

I think with the younger people, as far as the drinking problem goes, I think the main thing is the motivation of the man himself, at what particular level he stops and he decides he does have a problem of drinking.

I think at that particular point your motivation comes into force at that particular time, if you have the proper man that is skilled, maybe a paraprofessional, one that has had a drinking problem before, combined with the skill of the man with the MSW, and you have a prepared program at that particular point, I think you can stop him if you can work the motivation on the man.

Mr. MILLER. I do not think it is possible to say that any one treatment will be effective for all alcholics. We have in one city which I know in the Salvation Army there are four separate and different programs for alcohol abuse treatment. Some of those programs go in contrary directions. None of them meet the needs of all, but all are effective with some. Their needs to be a variety of programs. I do not think there is any one direction which can be adequate for all needs.

Mr. CARTER. In other words, the treatment should be tailored to the individual's requirements or needs?

Mr. MILLER. That may be difficult to do when you are trying to do it effectively with many different people, but certainly individualization of the program is necessary, and there needs to be facilities on a broad enough spectrum of different types of programs to meet the needs of various people.

Mr. PRATT. We have tried almost 25 different approaches over the last 20 years in various forms of treatment. We have found that transactional analysis, which is a psychological form of treatment, has given us by far the best recovery. We have found when men voluntarily accept Alcoholics Anonymous, there is a very high——

Mr. CARTER. When will they accept?

Mr. PRATT. That is the problem we have of offering Alcoholics Anonymous in a treatment center. Very often they will not accept. So we had much more success when we gave psychological treatment under transactional analysis, and I think one of the studies that we have to make is the comparative success of the various approaches.

I do support many approaches but I think some in our experiences are far better than others.

Mr. WOLFE. Dr. Carter, I would like to support what the major from the Salvation Army said. I think the Institute has taken the approach there are different kinds of alcoholic people with different kinds of needs. That is why you see around eight or nine different population groups served by the Institute—Indians, poor people, Spanish speaking, and women and drunken drivers. I think it was the very thing that the major said that focused on the individual differences so that the programs indeed are responsive to the needs of alcoholic people that are being served, and that has to continue.

Mr. CARTER. Thank you very kindly.

Mr. ROGERS. Mr. Hefner?

Mr. HEFNER. I think we have to talk very strongly in terms of prevention. I think one thing that Major Miller said is a bit sad but it is so true. Many times, as far as drug abuse and alcoholism are concerned, somebody who has been there is much more effective than all the directives and all the literature you can put out. I think this is one area we need to work in.

I know this from my own experience in the schools in my State. I have worked very closely with high school drug abuse programs, and we brought in some former drug addicts. They were much more effective than somebody from the Attorney General's office, or another State agency.

I think this is one area we should exploit to its fullest. If you have somebody giving testimony who has been there, it is much more effective.

One of the things Dr. Carpenter alluded to, was polio. Do I read you right to say that you believe that in the foreseeable future it is possible to come to grips with the disease of alcoholism. Maybe to have some drug or some inoculation to solve the problem of potential alcoholics?

Mr. CARPENTER. I used polio as an example of scientific success. I just read a book on polio, that it was in existence for 1,500 years before Christ, and did not get its name as a clinical entity until 1840. It was knocked out early in the 1960's. During that period the people, especially in the forties, in the thirties started running into these kinds of conferences and having these kind of confusions, where there was argument and contradictory evidence, and so on.

Even though it is not at the present time the same kind of problem that alcoholism is, it is not the same as alcoholism, there is no reason to believe because of the present confusion that we would not solve it, and that we will solve it by knowing a lot about it, and that is done by research.

And to answer your question more directly, if we put in 30 years of research, and it is very expensive, we still will be cost effective on it because we would not have to go on forever paying for therapy, services, and so on. Research is always cost effective.

Mr. HEFNER. I understand. I think polio was determined to be a form of virus. Am I right?

Mr. CARPENTER. Yes, sir.

Mr. HEFNER. Are you familiar with the work in our own State of North Carolina that Dr. Ewing is doing?

Mr. CARPENTER. Some of it.

Mr. HEFNER. We had a meeting with Dr. Ewing. I regret I am not as knowledgeable as I should be. I would like to get some data we had then. He sees, within the foreseeable future, a breakthrough in research to show that alcoholism could be related to genes.

Mr. CARPENTER. Yes, sir.

Mr. HEFNER. And that it would be possible to determine how susceptible a person would be in becoming a potential alcoholic. This could go a long way toward the problem we are confronted with.

Are you familiar with any of this research?

Mr. CARPENTER. Yes, I am. We have some going on at the Center of Alcohol Studies at Rutgers. As you know, the difficulty in tracing heredity of alcoholism, the difficulties are very great, and the studies that have been done, primarily by Goodwin, have been inconclusive in a certain sense, statistically.

There is another possible attack on it and that is direct biochemical attack. At the present time, for example, two known steps in the process of the metabolism of alcohol are known to be genetically determined. We do not know yet whether or not there is a difference between these isoenzymes and alcoholism and normal people. That is one problem.

Furthermore, we cannot get the livers of alcoholics to do the studies with. Hospitals will not give them up.

The other problem is if we knew this we would still have to show it was related to alcoholism in the sense that it was causative, because it is a part of the process that nobody yet thinks is part of the cause of alcoholism, but it serves as a model that would be independent of the kind of studies that get done where you trace families—I have forgotten that name—genealogical studies, which are so hard to do. I think a direct biochemical, a genetic attack is possible.

Mr. HEFNER. You do think perhaps there is some hope in the area that Dr. Ewing is studying?

Mr. CARPENTER. I do not know what he is doing, but the general area of genetics I think is very important. If that is what he is talking about, the answer is, yes. I do not know specifically what he is doing on this.

Mr. HEFNER. We are all potential alcoholics?

Mr. CARPENTER. I do not think so.

Mr. HEFNER. Well, you would support the theory that there is a continuum——

Mr. CARPENTER. Genetic material that interacts with the environment to produce alcoholism and if you have all of the genetic material and you have a drink, you become alcoholic, and if you have none of it you can have alcohol going out of your ears and it will not make any difference.

That is what I think, it is very hard to prove but it is a workable hypothesis, it is becoming more workable all the time.

Mr. HEFNER. Well, we are almost all predestined for something.

Mr. CARPENTER. That is true.

Mr. HEFNER. Somebody made the statement one time that it all depends on what social position you belong in: if you are wealthy, and you drink, you are eccentric; if you are poor and you drink, you are a drunk. So, there is a distinction there.

No further questions.

Mr. ROGERS. Thank you.

We have a call to the floor.

Let me ask this. Would you indicate either with a yes or no whether you think it would be prudent to turn over block grants to the States rather than continuing a Federal program.

Would you tell me whether you think it would be well to do that or not?

Mr. GORMAN. No.

Mr. DAVIS. No.

Mr. ROGERS. Could we go down the line and just——

Mr. WOLFE. No.

Mr. DAVIS. No.

Mr. GORMAN. No.

Mr. ROGERS. Is there anyone who would agree it should be done?

Mr. PRATT. No.

Mr. ROSE. No.

Mr. ROGERS. Well, that is very helpful to the committee because we will be looking at——

Mr. GORMAN. It has been tried before, and I think it would negate everything we tried to do in bringing the visibility of alcoholism to the American people. Now, we will call it health revenue sharing instead, and people will say what is that, is that something to eat?

Mr. ROGERS. Thank you so much for your presence. The committee is grateful to each of you for being here and the committee will stand adjourned until 2 o'clock this afternoon when we will conclude with the witnesses listed for today.

The committee stands adjourned until 2 o'clock.

[Whereupon, at 12:05 p.m., the subcommittee recessed, to reconvene at 2 p.m., the same day.]

AFTER RECESS

[The subcommittee reconvened at 2 p.m., Hon. Paul G. Rogers, chairman, presiding.]

Mr. ROGERS. The subcommittee will come to order, please.

Dr. Carter is on his way. He should be here shortly, so I think we will start.

Our first witness this afternoon is Mr. Leonord Boche, president, Alcohol and Drug Problems Association of North America.

We welcome you to the committee, and your statement will be made a part of the record in full [see p. 78] and you may proceed as you desire.

STATEMENT OF H. LEONARD BOCHE, PRESIDENT, ALCOHOL AND DRUG PROBLEMS ASSOCIATION OF NORTH AMERICA

Mr. BOCHE. Thank you, Mr. Chairman.

As president of the Alcohol and Drug Problems Association of North America I represent treatment programs, individuals, and States. I make my living as the administrator of a local alcohol and

drug program in Hennepin County, which includes the city of Minneapolis, and it is out of that perspective as well as the perspective of my fellow treatment service deliverers, I would like to address the committee.

We need continuing Federal leadership in the field of alcoholism and alcohol abuse, and we need it on a categorical basis.

The Institute has provided leadership which makes it possible for local communities and for local elected officials to be able to appropriate the necessary funds for the implementation of local programing.

I come from a particular jurisdiction in which 75 percent of a $4.5 million annual commitment to alcohol and drug programs is coming out of local appropriations. If the Federal Government through the Institute does not provide an ongoing commitment it will discourage the commitment that local jurisdictions have made, because once again the local jurisdictions fear that the Federal Government has initiated and then is withdrawing when the going gets rough.

We are at that stage in delivery of services where we have taken on the challenge that has been presented to us, we have committed ourselves to particular courses of action, and we are in the midst of implementing what are very revolutionary strategies in the management of intoxicated persons and the delivery of rehabilitative services.

I come in behalf of my fellow service providers to plead for a continuing Federal commitment and leadership.

I think there are several areas where this leadership can and should be carried forth. The reduction of social stigma needs a national emphasis and national direction for it cannot be done locally.

Through the formula grants and the creation of State plans, coordination and integration of the delivery systems on a local and State level have taken place.

We strongly support the continuation of the formula grant program, and the increase of the minimum to $300,000 because, for the most part, we are not talking about small States, but rather large States with small populations.

We need assistance and leadership from the Federal level in areas of research which we cannot do on the local level. The directions that Dr. Carpenter earlier referred to are the kind of activities which will support us in the local delivery of services. We need leadership which the Federal initiative can provide in the areas of prevention and training.

I would like to share the experience in Minneapolis for it is not the same experience which Indianapolis has had regarding the repeal of public drunkenness laws. Mr. Pratt and I have discussed this difference previously. Minnesota repealed the public drunkenness laws effective July 1, 1971, and we have had 4½ years experience with the repeal. During this period of time we have had 36,000 admissions to our substitute detoxification program. We have had one death.

At the time of the repeal of public drunkenness the city of Minneapolis had 1,100 people who were classified as desocialized, chronic alcoholics residing on skid row. Today, that number has been reduced to 256.

Last year we had admitted 4,800 people to the substitute detoxification program. Less than 5 percent of those people fit into the chronic desocialized category.

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We believe that it is possible to make significant breakthroughs, and we have witnessed great progress in removing the chronic drunkenness offender from the criminal justice system and serving that person in the health and social service care systems.

Under the old system of arrests about 12 percent of those people who were processed through the court went into extended treatment. Under civil management that percentage has increased to 40 percent, and we believe that we have an experience base that speaks affirmatively to the policy of repeal of public drunkenness laws.

I will support Mr. Pratt's contention that it is necessary to have a continuing treatment system. It is not enough simply to substitute detoxification. There must be a continum of care and basic smorgasbord of rehabilitation if the strategy is to be effective.

In my testimony I have made comments regarding income from taxes on alcohol and in so doing it should not be construed that those comments are in support of dedicated funds, but merely those comments in my written testimony were to illustrate two facts. (*a*) That a minority of consumers of alcholic beverages consume a disproportionate amount of the total alcoholic beverages sold.

The California figures estimate that 10 percent of the consumers are consuming 50 percent of the product. We are talking about sick people who are consuming great volumes.

(*b*) The second point of illustration is to once again remind you as our elected representatives that a very small portion of the Federal income from alcohol comes back into the treatment system.

We very much want and support the continuation of the authorities of the National Institute, and though we may have offered through our staffs some suggested changes in the bill, the importance of continuation substantially overrides some of the concerns we have for individual changes of our own judgment.

I will be happy to answer any questions you may have.

[Mr. Boche's prepared statement follows:]

STATEMENT OF H. LEONARD BOCHE, PRESIDENT, ALCOHOL AND DRUG PROBLEMS ASSOCIATION OF NORTH AMERICA

Mr. Chairman and members of the subcommittee, it is a pleasure to appear before you for the Alcohol and Drug Problems Association of North America (ADPA), and to have this opportunity in behalf of the agencies, individuals and state programs that make up our membership to support your efforts to extend the program authorities under the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act. The federal leadership and initiatives made possible under these authorities must be continued. They have been crucial to the development of a federal, state, and local partnership in which governmental and nongovernmental organizations and resources have increasingly committed themselves to deal with the broad spectrum of economic, social and personal consequences that result from the use and misuse of the beverage alcohol. A diminished federal involvement at this stage would jeopardize the commitment to this partnership. It is not a matter of a lot of federal dollars; the issue is one of national policy leadership and the continued and active participation of the Federal government.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has managed to stimulate a broad coalition of interests in spite of the uncertainty of and inadequate support from the HEW and Administration. Repeated attempts to impound or rescind funds and to kill this national effort after its first year of operation in 1972 have not helped. Now it appears that the Federal involvement is on the brink again. We understand that alcoholism programs will be among those included in an Administration proposal for a massive consolidation of federal health programs into a $10 billion revenue sharing package.

Your initiative to extend the program authorities under the Act is reassuring. It represents a determination to support continued Federal involvement in efforts at every level to deal with alcohol abuse and alcoholism. In contrast, the Administration's proposal represents a diminution of their obligation to implement the Act and on continuing any portion of their responsibilities for national policy leadership. We need the continued involvement of the Federal government and commend you for your support.

There are certain things the Federal government can do that the care givers cannot. The Federal government under existing authorities has provided the circumstances in which program development has taken place. Under-served populations have received attention, employee assistance programs have been initiated and community based programs have been stimulated. The formula grant program has served as the catalyst to the formulation of coordinated state delivery systems in which the federal-state-local partnership has in fact been defined and implemented.

The federal government can serve as a central repository of information on new knowledge and the activities of programs throughout the nation. No one else has this kind of responsibility. A sharing of these experiences with care givers will assure the continued growth in the quality of services and represent a unique function for and contribution by the Federal government.

The Federal government is unique in its capacity to support national efforts to reduce the stigma associated with alcoholism and to prevent the misuse of alcohol. It can involve the mass media and stimulate public service slots. It can gather as well as develop materials for local use. It can respond to the growing awareness of the need to modify attitudes and behaviors that contribute to the misuse and especially the excessive misuse of alcohol. In California, for example, 10 percent of the drinking population is paying 50 percent of the $600 million in federal excise taxes. These kinds of data help to define the importance of developing effective prevention programs on the responsible use of alcohol. We believe there is an urgent need for a major prevention effort at the national level to supplement the present support for treatment, training and research.

Research is another example where the Institute needs to provide more and continued support. The intramural research program in particular is inefficient and remains isolated at St. Elizabeth's Hospital. Congress could direct the HEW to move the program to a setting and climate that is more conducive to the collaboration of alcoholism researchers and other researchers from such areas as heart disease, cancer, research of the brain, etc.

Another Federal responsibility is the convening of a national advisory group of distinguished citizens from the broad spectrum of interests in this field to consider national policy directions and program priorities. A National Advisory Council on Alcohol Abuse and Alcoholism was established by the 1970 legislation but it does not assure this broad representation. At present, for instance, there are no care givers represented and there is no State Alcoholism Program Director on the Council. ADPA would recommend an amendment or expression of Congressional intent to assure a more representative makeup to the Advisory Council. Perhaps the members should be drawn from the governmental and nongovernmental organizations and individuals who have become involved in this field. Or, we might draw from and somewhat modify the statute that established the National Advisory Council on Drug Abuse. It could read as follows: "The appointed members of the Council shall represent a broad range of interests, disciplines and expertise in the alcohol area and shall be selected from outstanding professionals and paraprofessionals in the fields of medicine, social work, education, science, the social sciences and other related disciplines, including elected officials, who have been active in the areas of alcohol abuse prevention, treatment, rehabilitation, training, research and related public policy considerations."

The foregoing observations emphasize the continuing role of the Federal Government. It complements other governmental and nongovernmental efforts at the national, state and local levels. HEW and the Administration are attempting to abrogate their responsibilities. They need to know that Congress intends to continue the Federal role and expects more support from HEW and the Administration in the implementation of the Act. Passage of H.R. 11317 will communicate this message and we urge you to renew these authorities without delay.

There is a need for this kind of affirmative action lest state and local governments despair at having responded to another Federal initiative only to have the Federal Government drop out. States and local communities, for example, have responded to Federal leadership in the decriminalization of public drunkenness.

Twenty-four (24) states have taken this legal step and most are at the point of implementing the law. If the Federal Government no longer considers this an important area of support, the effect would be demoralizing to many of the local units of government like my own where the bulk of the costs for the implementation of a community care approach to the problem are borne by them.

The Federal investment in alcoholism services has the distinction of providing one of the greatest payoffs, both in returning citizens to useful productivity and in generating state and local funding that far exceeds the Federal commitment of dollars. Formula dollars in Florida represent only 20 percent of the State's funding for alcoholism programs; in California the total alcoholism budget for fiscal year 1975 was $29.8 million. The formula share was $4.5 million. All this has been achieved without a matching requirement.

The existence of the Institute and these modest appropriations continue to provide leverage for uncovering additional sources of funding for alcoholism services. State and local sources have responded, and on occasion, revenue sharing dollars have been used by city fathers to support a halfway house program. Other Federal health care and social service dollars are being mobilized to address alcoholism and related conditions. We are far from having sufficient support for those who need care. Treatment facilities are still inadequate to meet the need as are funds to support such services. But we are making progress. In those states where health insurance has been made available to this population, great strides have been made in the private sector.

Federal support has helped to stimulate a growing number of national, state and local groups to commit and focus their resources and priorities in this area. Over 60 organizations joined in December of 1974 to sponsor the North American Congress on Alcohol and Drug Problems. The organizations ranged from the National Council on Alcoholism, the Drug Abuse Council, and our organization to the American Bar Association, American Medical Association and other professional associations to groups concerned with the full range of community priorities like the U.S. Conference of Mayors, National Association of Counties, National Congress on Parents and Teachers and the AFL–CIO.

A Funding Task Force was an outgrowth of the North American Congress. The ADPA has served as the Secretariat for the Task Force as it has been for the North American Congress. This Task Force reviewed funding sources for citizens with alcohol and drug problems. There have been four committees of the Task Force located in the West, Southwest, Midwest and East.

The Task Force drew from the wide range of experiences among its membership to produce a report which identifies and describes funding resources as they really exist and impact service delivery. It is the most comprehensive examination of the funding issue that I have seen and very relevant to the legislative authorities on which the Subcommittee is holding hearings today. I will not take the time to review this reference, but will provide a copy for the record.

To conclude, the ADPA fully supports your initiative to renew the three authorities under the Alcoholism Act through September 30, 1979. A number of additional amendments and other suggestions have been mentioned. Also, I believe a number of possible amendments were shared with the Chairman in early December when you discussed renewal of the authorities with Mr. Gorman and Mr. Beauregard. We would support those amendments as well. But I want to put our support in perspective.

ADPA is interested in Congress' favorable consideration of these amendments only so long as they do not delay the renewal of the basic authorities contained in the present H.R. 11317. Our concern and hope is that these authorities will be renewed before the end of March so the programs under this Act can be considered during the House Appropriations Committee hearings on fiscal year 1977 funding. We do not want to provide the Administration and HEW any additional excuses for delaying the implementation of this Act.

This concludes the formal part of my testimony. I will be happy to answer any questions that you or the members of the Subcommittee may have, Mr. Chairman. Again, thank you very much for this opportunity to testify.

Mr. ROGERS. Thank you very much for a very helpful statement and the facts you brought forth to the committee. I know it will help them in making a judgment.

Mr. Hefner?

Mr. HEFNER. Thank you, Mr. Chairman.

I apologize for being late and missing the earlier portion.

Ten percent of the drinking population is paying 50 percent of the $600 million in Federal excise taxes?

Mr. BOCHE. That is the evidence we have, that a small proportion, 10 percent, are in effect consuming approximately half of the beverage alcohol. When per capita consumption rate of so-called social drinkers, are compared with those who suffer from alcoholism, there is a great disparity.

Mr. HEFNER. Well, in a lot of areas, such as in my own part of North Carolina, the financial support for a lot of schools and a lot of local programs is made up with revenue from alcohol taxes.

Do you have any figures of how much the manufacturers of alcohol contribute to rehabilitation and research? Do they contribute their fair share for research and rehabilitation?

Mr. BOCHE. Mr. Chairman, Congressman, I do not have data in that regard. I know that we have made efforts between the treatment and rehabilitation community to develop common understanding between the rehabilitation community and the beverage alcohol community. As to the amount of total commitment, I do not have that data.

Mr. HEFNER. Well, does private industry, which is so vitally affected by job losses and time lost on jobs, contribute a share to rehabilitation and research? I would think it would be very vital in that sector.

Mr. BOCHE. I can refer specifically to our experience in Minnesota. Industry has supported the inclusion of rehabilitative services in private health insurance for employees. It means, in effect, that the employer is picking up the rehabilitative costs through provision of health insurance coverage.

We have found that this inclusion has been very helpful in terms of developing employee assistance programs and rehabilitation policies within the employment sector.

Mr. HEFNER. I have no further questions, Mr. Chairman.

Mr. ROGERS. Dr. Carter.

Mr. CARTER. Would you agree that the problem of alcoholism has increased in recent years?

Mr. BOCHE. It is difficult, Mr. Chairman, Representative Carter, to say that the problem has increased. What we are very sure of is that it has become much more visible. There are some reasons to think that what we have is the iceberg coming out of the water. With a broader understanding and with the reduction of social stigma, we are now able to treat people who before were hidden.

I am not convinced that our alcohol problem is larger but rather that we are, in fact, starting to create the conditions out of which we can address it.

Mr. CARTER. Are you satisfied with the efforts that have been made by—on the Federal level to assure coordination of alcoholic treatment programs?

Mr. BOCHE. I believe that the strongest vehicle that has come through this legislation has been the formula grant program, and the requirement of State plan associated with the formula grant. This has gone a long ways to pull together State rehabilitation efforts and the faster interrelationship between the private and public sector. We are more able to look at one rehabilitation system rather than competing systems.

I believe that this—shall we call it the carrot of Federal funding?—has gone a long way to create the conditions out of which coordination takes place.

Mr. CARTER. Has there been much research actively under the act?

Mr. BOCHE. My observation of it is that the research that has taken place through that particular vehicle is very practical research around problem solving. It may be described as management research more than basic long-term research. I believe that basic research is best handled by the Institute rather than by the States or local units of government.

Mr. CARTER. I understand that one of the responsibilities of the National Advisory Council on Alcohol Abuse and Alcoholism is to make suggestions for future improvements.

What recommendations have been made and what has been the result?

Mr. BOCHE. I cannot actually report to you the activities of the Advisory Council. I think what I can respond to is that the Advisory Council has not been as representative as many of us would like to have seen it.

I feel that there are certain gaps in its membership. I do not feel that that the rehabilitation community, the people who are on the firing line, are adequately represented. I do not believe that the States are adequately represented on that Advisory Council. I believe it to be a productive mechanism, but I would appreciate the expression of congressional intent as to its makeup.

Mr. CARTER. Then you do not think that the Council is broadly representative?

Mr. BOCHE. That is my personal judgment—yes.

Mr. CARTER. What have been some recent studies which link drinking to heart muscle damage and deterioration of the brain? Have you heard?

Mr. BOCHE. I will have to pass on that. The material that I have available to me is pretty much that which is in the popular press, and I would have to turn to some of my scientific friends.

Mr. CARTER. Do you agree with this finding?

Mr. BOCHE. I believe this is an area of research that should have attention and that the basic area of alcohol research should be done in the context of research with other health problems.

Mr. CARTER. Thank you, Mr. Chairman.

Mr. ROGERS. Do you think there should be separate State agencies, or should alcohol be combined with mental health?

Mr. BOCHE. I believe that there needs to be an identifiable program. I see that States organize differently and under different administrative philosophy but I believe there is a need to have clearly identifiable for alcoholism a program, whether constituted within mental health or within the social service agencies. I think the issue is identity rather than organizational separateness.

In that regard, I share with the committee that I am one of the few people around who came through the alcoholism field who is now director of a mental health program.

Mr. ROGERS. And I was wondering what was the pyramid you were talking about turning around?

Mr. BOCHE. Yes, sir.

Mr. ROGERS. How is the best way to do that?

Mr. BOCHE. I would like to address that pyramid, if I might. We find that in the agency in which I am involved, which is a local service delivery, our administrative costs are about 11 percent. Of that 11 percent, approximately half of it is required of us by State and Federal regulations, which we would not include if it were not necessary to meet external requirements.

So I do not share the same concern that Dr. Chafetz did earlier. Specifically, I believe I do not share it because we are operating outside of a hospital context and outside of a rigid medical model using the full range of paraprofessionals, and using a social service model which provides us a great deal more flexibility in which we can incorporate medical services as supportive services within that delivery system.

Mr. ROGERS. Does Minnesota treat alcoholism as a crime?

Mr. BOCHE It does not. It repealed the public drunkenness law in 1971, and the legislature directed that each area of the State must have a detoxification program no later than June 30, 1973. We conformed. We have a statewide detoxification system and alternative care system together along with the repeal.

Mr. ROGERS. Thank you so much.

Mr. HEFNER. You may have to go back and refresh me. You quoted the figures that so many alcoholics were in the streets, or whatever.

Mr. BOCHE. Yes, sir.

Mr. HEFNER. As compared to this year?

Mr. ROCHE. With the repeal in 1971, the estimates were that we had 1,100 chronic de-socialized people suffering from alcoholism. The study that we have done this past year, within our delivery system, identifies 254 individuals who have ten or more admissions in any one year.

Mr. HEFNER. Where are these people?

Mr. BOCHE. There are several things I believe that has happened to the population. One is that we found that within the criminal justice system we were carrying on a form of "placement" and when we started to deal with these people within a health and social service system, we started to find healthier placements for them than simply running them through the jail. Some were placed in board and care homes and others in nursing homes, where the medical reasons indicated.

We were able to take out of that population sick and debilitated individuals who were routinely rotated through the criminal justice system.

Another group of people were frankly successfully rehabilitated, as Mr. Pratt has indicated. That that population, if given the appropriate treatment setting can respond and can recover. I think we have to admit that once this system was established and people were expected to improve, we found that less homeless men seemed to migrate into our city.

We got off of the trail, so to speak, of migrant chronic alcoholics who might come through Minneapolis, because we did place on these individuals as they came into our system the expectation that they should recover and that they can recover. Persons who do not like that kind of expectation, they tend to find another city.

Mr. HEFNER. This just would be a guess. Would you not say that the problem we have is closer to 10 percent of the population of this

country that 10 percent of the population are admitted alcoholics? Is that not correct?

Mr. BOCHE. The figures which has been accepted for employed population is 10 percent. When you get outside of the employed population and start including the young and the aged, your figures become diluted, though obviously from previous testimony there are drinking problems among the young and among the aged.

Mr. HEFNER. Probably their alcoholic problem is more severe than we would like to believe.

Mr. BOCHE. I believe that is the case, once we have the ability and courage to permit the problem to come out in the open.

Mr. HEFNER. Thank you, sir.

Mr. CARTER. What is your rate of recidivism among the patients you treat?

Mr. BOCHE. These 254 individuals constitute less than 5 percent of the people admitted they consume over 15 percent of our services, so for this population we do have multiple use of our health and social service facilities. As we looked at the population one of the questions we raised is how low is it realistically to expect this population to be reduced in simple management terms?

Mr. CARTER. I mean how many of your alcoholics treated in your institutions have to come back for further treatment? How many are cured?

Mr. BOCHE. All right.

Mr. CARTER. Permanently.

Mr. BOCHE. Well, I think what we have focused on is a criteria of success which would not fall in the category of permanent cure, but would fall into the category of improved functioning, social, family, and employment.

In other words, if you want to put it in very clear economic terms, the criteria of success is directed to the question, has the individual after care been able to improve in terms of holding a job, and supporting his family? We are using these criteria for treatment success.

Now, obviously we have an interest in people's long-term recovery and we do operate under a philosophy of total abstinence as an intricate part of the treatment system, but this does not deny the fact when we are looking at outcomes we can document in terms of social productivity.

Mr. CARTER. And you really cannot document the rate of recidivism then?

Mr. BOCHE. On that basis, it becomes more difficult. We can with certain populations such as our chronic friends because we see a lot of them, for these 254 individuals.

We know that these 254 individuals are costing us in documented social costs about $9,000 a year.

Mr. CARTER. How many psychiatrists does your center employ?

Mr. BOCHE. None. We have one consultant who basically work through our direct care giving staff which are counselors and social service people.

Mr. CARTER. How do you pay this psychiatrist?

Mr. BOCHE. We retain her on a contract basis from the University of Minnesota and serves approximately 15 percent of her time.

Mr. CARTER. Fifteen percent of her time. How much does that amount to in dollars?

Mr. BOCHE. I believe we are paying at a dollar rate of approximately $25 an hour.

Mr. CARTER. $25 an hour?

Mr. BOCHE. Yes, sir.

Mr. CARTER. Thank you.

Mr. ROGERS. Thank you so much for being here.

Mr. George Hawkins, executive director of the United Indian Recovery Association, had to leave but he desires his statement to be made a part of the record, and without objection it will be made a part of the record at this point.

[Mr. Hawkin's prepared statement follows:]

STATEMENT OF GEORGE HAWKINS, EXECUTIVE DIRECTOR, UNITED INDIAN RECOVERY ASSOCIATION

First, Honorable Mr. Rogers, I am most grateful in being afforded this opportunity to appear before your Subcommittee and secondly, I must state that I am not an official representative of Indians.

I am only giving my judgmental conclusions derived from my past and present positions in the field of Alcoholism.

I am what is generally termed a "recovering alcoholic" and at the inception of this period, I helped to create an organization (1969) termed, "Indian Development Center", in Oklahoma City. This organization was governed by a Board of concerned Indians, assisted by an Episcopal Father, and had set as it's goal: To help the Urban Indians, primarily the Alcoholic, who was and still is in desperate straits. We initiated this effort with a one time grant of $2,000 from the National Committee on Indian Work (an Episcopal affiliate) and a continuing donation of $100 per month from the Episcopal Diocese, headquartered in Oklahoma City.

I was elected Chairman of the Board and Executive Director, possibly a conflict, but I seemed to be the logical person to act as Director because I worked for the Kerr-McGee Corporation, in Building Maintenance (Janitor) and my hours were 5:00 p.m. till 1:00 a.m., therefore, I could keep the office open most of the day, again obviously, I needed the job with Kerr-McGee as we had no resources to pay any salaries and any other resources we needed for our clients. Such as rent money, food, etc., came from churches, private citizens and our own resources.

At this junctive, I would like to stop and attempt to make this point: The leadership in the Indian Community, City Government, County Government and State Government did not and to a great extent, still does not realize that the Alcoholic needs and deserves help. Most programs stem from the efforts of "recovering alcoholics" and could possibly be pin-pointed through the initial efforts of two men, forty years ago.

With the establishment of the O.E.O. and the subsequent enactment of the Hughes Act of 1970 (P.L. 91–616), the National leadership determined that the Alcoholic needed and deserved help, and at that point, funding from the National level was initiated to help the facilities that were emerging and struggling to stay in existence. Subsequently, I retired from Kerr-McGee and moved on to Directorship of the Cheyenne & Arapaho Rehabilitation Center in Bessie, Oklahoma, as a full time salaried employee.

There was established nine (9) more Indian Alcoholism Programs in the states of Kansas, Oklahoma and Texas, through the auspices of P.L. 91–616, and a fimmer foundation was established to help the Alcoholic and also to attempt to sensitize the leadership and members of the tribal entities, municipal, County and State constituencies to the problem of Alcohol and Alcohol Abuse.

During this process, we (the nine Directors) came to realize what a tremendous undertaking this was, getting across the idea that Alcoholism is a respectable and treatable disease, to the leadership of both the Indian and non-Indian communities and because the Directors were totally involved with the Alcoholic and could not concentrate on the effort to erase the stigma of Alcoholism from the minds of the general public, a central office for research communication and advocacy was needed for these three states.

The Federal Government has already invested, through PHS Indian Health Service ($25,000) and NIAAA ($75,684), a total of $100,684 and we are informed that we have to stop in the middle of our work. Is this good management?

A proposal was promulgated and submitted to NIAAA and was awarded for one year and the second year would be granted subject to the availability of funds. (Keep this in mind, as we have been notified, verbally, that there are no funds available for the second year and we have to close up shop January 31, 1976). I was selected to be the Director of this organization, "Regional Indian Field Study". Advocacy, we feel, is needed because treatment for Alcoholism is so new that the established entities do not know where to place them, i.e., State and Municipal laws, ordinances, anything in the area of regulating function, a case in point, we tried to establish a half-way house in Coalgate, Oklahoma. The owner of the facility was in agreement and a contract was signed but a group of neighbors did not want a bunch of "drunks" in their neighborhood, so they circulated a petition and had that particular facility re-zoned, so we had to find another place.

This also holds true with some private agencies, Insurance Companies for instance, while Director of C & A Rehab Center, I negotiated an Insurance Policy in which we were classified as a Rehab Center with the Premium to be $118.00 per annum. The second year, I was informed by the Insurance Company, that they had reviewed their contract and we would have to be placed in a different category: a Mental Psychopathic Institution-Governmental and our Annual Premium would be $109.00 per bed, total $2,018.00.

During this period, I was on the Planning Committee to establish a National Indian Board on Alcohol and Drug Abuse, and am now an Alternate Member.

Member of the Oklahoma Alcohol Advisory Board, authorized by Act No. 629, (Okla. Stats).

Member of Task Force No. 11, Alcohol and Drug Abuse, authorized under P.L. 93-580, which established the American Indian Policy Review Commission.

In summary, your Honor, I would like to present these observations and recommendations.

1. In general, the Indians realized that through the Hughes Act of 1970 (P.L. 91-616) we had hope and help that something could be accomplished in the alleviation of the number one Health problems of the Indians today.

2. Specific provision must be incorporated within the legislation to:

(a) Insure that Indians will be in a policy making position.

(b) Specific amounts will be set aside for Indians.

The Hughes Act afforded a group of concerned citizens not affiliated with any governmental structure, either Indian or non-Indian to do something and for this reason categorical grants should be continued. Past history indicates that the various governmental structures have been very reluctant to do anything in the field of Alcoholism and Alcohol Abuse, either to approve the establishment of or appropriate any funds for programs. It has been only through the leadership at the National level that any concerted thrust is being made.

The Indians find it very difficult, if not impossible, to get any help from the State or local level. (Formula Grants)

In reference to 2a), we feel that the intent of Congress is sometimes subverted, as is indicated in the Act of 1934 (25 vsc 472) (also, see Mancori v. Morton, 94 S. Ct. 2474), which legislation established, and reaffirmed, "The Secretary of the Interior is directed to establish standards of health, age, character, experience, knowledge, and ability for Indians who may be appointed, *without regard to Civil Service Laws,*# to the various positions maintained, now or hereafter, by the Indian Office, in the administration of functions or services affecting any Indian Tribe. Such qualified Indians shall hereafter have the preference to appointment of vacancies in such position." (# emphasis supplied)

After over forty (40) years, or possibly two generations, have we been given the opportunity to chart out own lives? You could review the personnel witnin this function and determine how the intent of Congress has been carried out.

Mr. ROGERS. Our next witness is Dr. Tom Price, executive director, Council of State and Territorial Alcoholism Authorities.

We welcome you to the committee, and you may proceed as you desire.

STATEMENT OF TOM PRICE, EXECUTIVE DIRECTOR, COUNCIL OF STATE AND TERRITORIAL ALCOHOLISM AUTHORITIES

Mr. PRICE. Thank you, Mr. Chairman, members of the committee. I am here because Mr. McCord, who is our president, could not be here.

The testimony is presented in his name, and I will read it and be happy to answer any questions.

Before I begin, on the way up here, the alcohol and Drug Problems Association of North America asked me to submit this document on funding sources for alcoholism programs, Federal funding sources, basically, for the record.

Mr. ROGERS. Without objection, we shall place the document in the record following your statement [see p. 94].

Mr. PRICE. I will leave this here.

The Council of State and Territorial Alcoholism Authorities—CSTAA—is pleased to have this opportunity to appear in support of your initiative to extend the program authorities under the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act.

Our organization is the national association for the 56 State alcoholism program directors who administer the formula funds authorized under the act, and like the National Institute on Alcohol Abuse and Alcoholism, NIAAA, at the national level, are charged in each of the States to provide leadership in the development and coordination of efforts to help citizens deal with the use and misuse of the beverage alcohol.

Most State governments had established alcoholism programs prior to the passage of the Federal act in 1970, and were active in efforts to obtain Federal legislation. Oregon, for example, had a program as early as 1943. Georgia, under then Governor Talmadge, established its program in 1953; Minnesota started prior to 1960; your own State of Florida initiated a program in the mid 1950's. South Carolina—where Mr. McCord is—passed legislation in 1954 to create an alcohol rehabilitation and adult education program.

Mr. McCord became the first full-time director in 1959 and has held the position ever since.

But it was the program authorities under the 1970 act, and their initial funding in 1972, that committed all the States to participate in a Federal, State, and local partnership in which governmental and nongovernmental organizations and resources have increasingly committed themselves to deal with the multifaceted economic, social, and personal consequences that result from alcohol abuse and alcoholism.

Mr. Chairman, we commend your initiative in the renewal of these program authorities and commend you for the leadership and support you have given to these efforts. We recall your determination in 1969 to enact the initial act, and over the years since then, your persistent support in the face of many other priorities for your time. You and your colleagues in Congress have been steadfast in your support in spite of the administration's attempts to kill the national program after its first year of operation in 1972, to impound funds in 1973, and to rescind or otherwise delay the expenditure of funds appropriated by Congress.

State and local programs have become more viable under the Federal policy leadership of the NIAAA and the determination of Congress to see that this leadership remains strong and undiminished. Inconsistent and insufficient support by HEW and the administration, however, has hindered these efforts and, in our judgment, the ability of the Institute to adequately implement the act and its many fine provisions.

For example, new and higher level positions have been authorized for NIAAA by Congress, but HEW has not filled them. An interagency committee to achieve greater coordination at the Federal level has not been convened fully a year and a half after Congress, by statute, directed the Secretary to do so.

States were willing to help implement and monitor compliance to the provision to prevent hospitals from refusing admission for medical conditions soely because of alcohol abuse or alcoholism. Responsibility for its implementation was delegated to the Civil Rights Division of HEW, but thus far, to our knowledge, regulations and procedures have not been issued. Maryland, for instance, is trying to implement the provision with little or no help from HEW.

Such foot dragging on the implementation of some provisions of the act, and an on-again, off-again approach to funding State and community assistance efforts have caused much uncertainty at State and local levels. For example, the Governor of Florida, in fiscal year 1973, planned to identify alcoholism as the State's No. 1 health priority, and to ask for up to $16 million for alcoholism services, a six- to eight-fold increase in State funds. When the administration cut back to its commitment and attempted to impound over $70 million of NIAAA funds, the Governor modified his plan to a $4 million effort.

Other resources have been wasted or lost from shifts in Federal operating policies. Expectations have been reduced and personnel hard to retain. Much has been accomplished in spite of these difficulties, but there is a need to find ways to develop a more stable Federal, State, and local partnership so that resources are forthcoming and stable at all these levels.

Most simply and immediately, the HEW and administration need to know the Congress intends to have this national effort implemented and not derailed through a premature consolidation into a health revenue sharing package. Passage of H.R. 11317 will reassert this intent and we encourage you, first and foremost, to move ahead to renew the authorities.

There are a number of additional amendments that would improve the accountability, quality, and coordination of governmental and nongovernmental program efforts at Federal, State, and local levels. I believe these suggestions first were shared with the chairman in early December when you discussed renewal of the authorities with Mr. Gorman and Mr. Beauregard. At this time, CSTAA would like to share with the subcommittee the specific reasons for our interest in these changes, and to put our support for these and any other suggestions in perspective.

We believe these amendments would further reinforce the program effectiveness of existing statutes and specifically improve the administration of the State alcoholism programs. At the same time, we want to emphasize that we are interested in Congress' consideration of these additional amendments only so long as they do not delay the renewal of the basic authorities contained in the present H.R. 11317.

CSTAA is cognizant of the crucial need to renew these authorities before the end of March if they are to be considered during the House Appropriations Committee hearings on fiscal year 1977 funding. Our primary interest and priority, therefore, is the extension of the authorities to authorize appropriations for State and community assist-

ance. With this perspective in mind, I will turn to some of the additional amendments we would support.

Section 102(1) of the act requires an annual report from the Secretary on the activities under these authorities. In our judgment, this has not been a very meaningful report. A more explicit requirement to include State plan information and information drawn from status reports on grants and contracts would increase the value of this report and help to relate these programmatic activities to the policy deliberations of the Institute. Specifically, we would recommend the annual report include an evaluation of the extent to which there has been Federal, State, and local program coordination in the development of comprehensive alcohol abuse and alcoholism prevention, treatment, and rehabilitation resources for every citizen. We would further recommend, as mentioned, the use of State plan information and information from status reports on grants and contracts as principal references in making such an evaluation. The intent would be to provide a specific application of these sources of data, so the Congress and the public could more realistically determine the value of their investments. It would emphasize the basic intent of these authorities as instruments of program development.

Section 302(a) of the act provides for a minimum allotment to any State of $200,000. We would support an amendment to raise the minimum allotment from $200,000 to $300,000, to provide to the States that receive the minimum grant their first increase since the formula grant program began in fiscal year 1972 when $30 million was distributed. As the appropriation has increased other States have qualified and received increases over the 1972 amount every year. Based on fiscal year 1975 amounts, a total of 14 States would receive an increase in the event the minimum is raised to $300,000. This number is based on the distribution of $52 million to States in fiscal year 1975. The total increase to the States would be $1,282,932.

We need to point out, however, that Congress has appropriated $55,500,000 in formula grants for fiscal year 1976, and hopefully, the amount for fiscal year 1977 will be more in line with this subcommittee's authorization of $80 million. Most States would receive an increase at the $55,500,000 level. The minimum States, however, would receive no increase. The increase from $200,000 to $300,000 in the minimum States, while admittedly affecting other States to some extent, is right and overdue.

Section 303(a)(10) requires the State programs in the submission of their State plan to set forth standards for facilities and services. This requirement was added under the 1974 amendments to the act. To date, 33 States have legislated or promulgated standards for licensing and accrediting alcoholism treatment facilities and programs. Twelve additional States are in the process of developing standards. Eight States have not acted on standards. The objective of such standards is to assure a higher quality of care to citizens who seek help from community resources. States have traditionally had responsibility for the licensing of facilities and the establishment of standards.

There are national groups such as the Joint Commission on the Accreditation of Hospitals that serve to complement the establishment of standards by States by national voluntary accreditation of programs.

There are also State and voluntary efforts to certify certain types of professional personnel. National efforts to facilitate certification of personnel are valuable to each State's attempt to assure adequate standards of care. National voluntary efforts provide for greater uniformity and higher quality standards among the States, a sharing of experience and knowledge, and contribute to the utilization of personnel in those States which agree to recognize the credential of a person certified according to nationally recognized standards.

The CSTAA would favor a specific amendment to support the efforts of States and other governmental and nongovernmental groups at National, State, and local levels to establish voluntary National bodies to facilitate the accreditation of alcoholism programs and the certification of personnel.

Specifically, the counsel would support an amendment to section 302 which would add a new subsection at the end thereof allowing for up to 2 percent of any allotment or allotments of the formula grant, at the discretion of the State, in support of these voluntary national efforts. The purposes would be to reinforce and supplement the legal responsibility of the States for standards under section 303(a)(10), and to support greater cooperation among governmental and nongovernmental groups at National, State, and local levels that seek to assure high quality care for citizens with alcohol drinking problems.

There has been increasing concern among State directors with HEW efforts to modify the Federal administration of the formula grant program. The Institute has been instructed to adopt a so-called simplified program and budget approach. Under this administrative procedure, the documents that, according to the law, the State "shall submit to the Secretary" to receive a grant can be retained in the State and instead, "incorporated by reference" as part of a simplified budget document. We believe such a procedure circumvents program responsibility and reduces contacts to a relationship between Federal and State fiscal offices. This management procedure eliminates the principal basis for a meaningful Federal-State program relationship, and further, makes impossible an adequate evaluation of the State programs by the Institute and any accountability for the use of these funds by the HEW.

The administration's so-called simplified approach would essentially eliminate the Federal program role.

It is our conviction that the process of preparing, submitting, and negotiating a State plan is an important part of establishing and maintaining a stable Federal-State partnership that is, in turn, responsive to changing local needs.

Therefore, we would favor such modifications as are necessary to section 303(a) of the act and expressions of congressional intent that would make explicit the requirement that the State plan, or any other modifications thereto, must be submitted to the Institute, and that no administrative modifications would be in keeping with this requirement.

State program directors have continually emphasized the importance of having alcoholism services available as an integral part of the broad spectrum of community care resources. With this in mind, we would support an amendment to section 311(b) of the act to make more explicit, in the case of projects supported by grants and contracts under this authority, the importance of utilizing existing community

resources such as community hospitals and convalescent centers, family service agencies, community mental health centers, and other community social service and counseling facilities.

The language of the act at present specifies the importance of utilizing community mental health centers. We are suggesting the explicit addition of other community resources as well.

Mr. Boche, in his testimony for the Alcohol and Drug Problems Association of North America, has recommended that the Institute commit more of its resources to prevention. The council also would support this priority by statutory modification, if necessary. A total of 28 States have identified prevention activities as a State plan priority for fiscal year 1975 and allocated a portion of formula grant funds to implement this priority.

Before any such commitment to legislation, however, we recommend the Congress insist on a more explicit understanding of what is meant by "prevention." Certainly we do not consider the periodic distribution of pamphlets a viable and effective approach to the prevention of alcohol abuse.

The notion of prevention is somewhat illusive and targeted funds for this purpose can and on occasion have been poorly used. Treatment that prevents the loss of human lives to alcohol abuse and alcoholism is a form of prevention. Attempts to involve individuals at an earlier stage in the development of their alcohol drinking problem may also be defined as prevention. At the other extreme, this Nation embarked in the early part of this century on a venture to prohibit the consumption of alcohol. This might be viewed by some as pure prevention. The Nation learned from that experience that we cannot prevent consumption and possibly learned something far more important, that prevention is essentially a personal decision. In our judgment a concered commitment to prevention must address itself to the modification of the social and cultural factors that encourage the misuse of alcohol. Positively, prevention efforts must address the social and cultural factors that enhance and support the individual's capacity to make responsible decisions in all areas of life.

As mentioned, there are 28 States that have identified prevention as a priority. Many have very exciting programs and we would be pleased to review these in more detail for the subcommittee. In my own State of South Carolina, we have a program called Operation Reach Out. These are services for elementary school age children of problem drinking parents. The purpose is to provide an opportunity for a normal social adjustment for this target population and to supply the services necessary for the healthful, emotional, psychological, sociological, and scholastic development of such children.

An interesting program is about to get underway in California. Governor Brown himself has expressed some personal concern for prevention and has authorized $1.7 million of State moneys for each of 5 years to do an intensive community prevention program.

This will be focused on neighborhoods and will use a model that was successful in the reduction of coronary heart disease. Many resources will be used including mass media and community education in neighborhoods, schools, and work settings. The attempt will be to change attitudes and behaviors that contribute to the excessive consumption and misuse of alcohol.

Basically, the program sends volunteers into neighborhoods and institutions of the community to work with individuals.

California plans to focus on one or two regions of the State on a demonstration basis. The expectation is that at the end of 5 years they will be able to measure significant reduction in excessive drinking. The measures will be based on such factors as whether there is a reduction in excessive drinking as reflected in a drop in revenues from alcohol beverages, whether there is a reduction in mortality from alcoholism, whether there will be changes in traffic deaths and accidents. This demonstration is funded entirely out of State dollars because there has never been enough Federal dollars to carry out such an extensive undertaking.

The CSTAA also supports the ADPA concern about the intramural research program at NIAAA. The program has remained at St. Elizabeths Hospital. This is not an efficient setting and is isolated from other research that is meaningful in the health field. We recommend that the Congress direct the HEW to provide a setting and climate that is conducive to greater collaboration by researchers in alcoholism with researchers in other areas like heart disease, cancer, research of the brain, et cetera.

In conclusion, Mr. Chairman, I would like to emphasize the growing viability of State programs. In 1975, only 4.3 percent of the formula grant went to an administrative overhead. The remainder was utilized in the States for treatment services, planning, coordination, training, intervention, prevention, education, and evaluation. Over 85 percent was spent at the local level and at least 50 percent went into treatment services.

The States have used the formula dollars to generate State and local commitments of funds and other resources. In your own State of Florida, for example, $11,691,519 was channeled into alcoholism programing from all sources in fiscal year 1974. Formula grant funds make up only 20 percent of that total.

Some 24 States have enacted a Uniform Act which includes decriminalization of public drunkenness. Eleven additional States have enacted some form of comprehensive alcohol abuse legislation. In this regard, the special grant for the implementation of the Uniform Alcoholism Intoxication Treatment Act, authorized by Congress in 1974, has been a strong incentive to the States in their passage of this basic legal foundation for a community care approach to citizens with alcohol drinking problems.

Thirteen States have enacted mandatory coverage for alcoholism treatment in group health and hospital insurance plans. This has been an interesting development in obtaining third-party payments for treatment. There are other sources of funds that are being explored and obtained such as funds under title XX of the Social Security Act. I would emphasize, however, that the continuation of Federal support for State programs and community efforts under this act is essential, in our judgment, to achieve the leverage necessary to consolidate participation in other health and social service funding sources.

The first half of the 1970's has helped to focus attention on the extent and nature of the problems of alcohol abuse and alcoholism in America. There is a great willingness to seriously consider a portion of resources to deal with these problems and a realization that the citizens affected can be helped. Further, there is a growing awareness that there must be a commitment to modify the social and cultural factors that encourage the misuse rather than the responsible use of the beverage alcohol.

This concludes the formal part of my testimony. Thank you very much for this opportunity to share our views and suggestions in support of H.R. 11317.

[Testimony resumes on p. 203].

[The funding report referred to follows:]

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ALCOHOL AND DRUG PROBLEMS ASSOCIATION OF NORTH AMERICA

FORMERLY NORTH AMERICAN ASSOCIATION OF ALCOHOLISM PROGRAMS (NAAAP)

PLAN NOW FOR ADPA 27th annual meeting — New Orleans, La. — September 12-16, 1976

FUNDING TASK FORCE
of the
NORTH AMERICAN CONGRESS ON ALCOHOL
AND DRUG PROBLEMS

Report
Contract 271-76-1009
with the

National Institute on Drug Abuse
Department of Health, Education and Welfare
Rockville, Maryland

December, 1975

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This report has been written pursuant to contract No. 271-76-1009 with the National Institute on Drug Abuse, DHEW. Points of view or opinions expressed herewithin do not necessarily represent nor reflect the position or policy of NIDA.

FOREWORD

At best, any report on funding of services in a field such as alcohol and drug problems reflects the beliefs and experience of the persons who prepare the report. Because the Funding Task Force of the North American Congress on Alcohol and Drug Problems includes members from only four areas of the nation, many experiences and points of view are unavoidably absent from this report.

The Funding Task Force intends to continue its work, and welcomes any comments or suggestions specifically about portions of the report, or generally about the funding of alcohol and drug abuse services. These comments should be addressed to Mr. A. H. Hewlett, Alcohol and Drug Problems Association of North America, 1101 15th Street, N.W., Washington, D.C. 20005.

We acknowledge with appreciation the support from the National Institute on Drug Abuse of the Alcohol, Drug Abuse and Mental Health Administration, U.S. Department of Health, Education and Welfare, that has made this report possible, and we particularly acknowledge the continuing interest in and support of the work of the Task Force by Dr. John Scanlon, Associate Director for Program Operations of NIDA, Mr. Melvin Segal and Ms Mary Cahill of NIDA's Office of Program Development and Analysis.

This report could not have been prepared without the very capable expertise and efforts of Nancy A. Wynstra, one of the founders of the Task Force, who served as the report's principal editor. Our thanks also to Mr. James Pearson of the Alcohol and Drug Problems Association of North America, to all Task Force members whose thinking and contributions made the report possible, and to Ms Vicki Granat and Ms Laurie A. Kalvig for help in the report preparation.

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REPORT OF THE FUNDING TASK FORCE

December 31, 1975

I. PURPOSE OF THIS DOCUMENT

Public concern about drug and alcohol abuse reached a high level by the middle of the last decade. Much of that concern was tied to the apparent relationship between these problems and the frightening increase in crime. But the problem was broader than criminal activity.

In the case of drug abuse, evidence suggested that a substantial level of "street crime" was committed by narcotic addicts to finance their drug need. Hallucenogenic drugs, barbiturates, amphetamines and cannabis were becoming ever more popular in "counter-culture" groups involving younger people and military personnel. For alcoholism, apart from the frequency of alcohol use as a factor in assaultive crimes, analyses of police arrest statistics in several urban areas revealed that as many as half of all arrests were for public inebriety. Chronic alcoholic persons were taking the time of the police, clogging the courts and crowding the jails, thus diluting the resources available for the criminal justice system to focus on crime. Analysis of highway accidents indicated that high blood alcohol levels were present in one or more of the drivers in as many as half of all fatal accidents on the nation's roadways. The incidence of alcoholism in the United States was estimated to be 9 million persons.

New and innovative methods for dealing with alcohol and drug problems were sought through many of the social, health and educational

programs enacted at the federal level from the middle 1960s.

.. An amendment to the Highway Safety Act of 1966 called for studies on the relationship of alcohol to highway accidents. As a result of these studies the Office of Alcohol Countermeasures was established within the National Highway Traffic Safety Administration of the Department of Transportation. Thirty-five Alcohol Safety Action Projects, employing varying combinations of countermeasures, were funded throughout the nation over a 3-year period. Several of these were picked up by state or local governments at the end of the demonstration period; ten continue to be funded by the Department of Transportation. Many of these programs proved highly successful in the reduction of traffic accidents in their respective areas.

.. The Model Cities Act of 1966, implemented by the Department of Housing and Urban Development, included provisions for the training of alcoholism and drug abuse counselors for inner city clinics in selected cities.

.. After passage of the Law Enforcement Assistance Act of 1966, special programs for the handling of drug dependent defendants were funded by the Justice Department's Law Enforcement Assistance Administration, as were detoxification centers for both alcohol and drug toxicified patients. More recently LEAA has funded drug diversion programs in 30 cities, based on a model developed by the Special Action Office for Drug Abuse Prevention.

.. In the President's Health Message to Congress of 1966, he announced

the establishment of the National Center for the Prevention and Treatment of Alcoholism within the National Institute of Mental Health. This was the forerunner of what is today the National Institute on Alcohol Abuse and Alcoholism. This announcement by the President followed two federal court decisions which held that chronic alcoholics could not be held criminally liable for public inebriety; drunkenness by these individuals was symptomatic of an illness and not a crime. The decisions called for more humane treatment within the appropriate health care system rather than handling through the criminal justice system.

.. Attention to alcohol and drug problems within the Community Action Programs of the Office of Economic Opportunity was given priority emphasis when Congress amended the Antipoverty Act in 1967.

.. The Veterans Administration, by administrative order in 1964, proclaimed that alcoholism should be treated under that diagnosis, rather than under other labels. At the time, despite the fact that there were 26 million veterans, most of whom were male and in the age group in which alcoholism is most prevalent, only a few VA hospitals were treating alcoholism as alcoholism and none were so treating drug abuse. There is now a special office on alcohol and drug abuse in the VA Central Office in Washington and treatment for these conditions is available in 71 VA Hospitals.

.. The Alcoholic Treatment Act for the District of Columbia, introduced in 1967 and signed into law in 1968, was the prototype for the Uniform Alcoholism and Intoxication Treatment Act promulgated by

the National Association of Commissioners on Uniform State Laws. The Uniform Law, which decriminalizes public intoxication, has been passed by more than twenty states and is under consideration by most others.

.. Two Presidential Crime Commissions were named in 1967 - one for the District of Columbia and the other for the nation as a whole. The reports of both commissions, published in December 1967, contained separate chapters on the problems of drug abuse and the chronic drunkenness offender. In response to these reports, in his Crime Message to Congress of 1968, the President asked for passage of the Alcoholic Rehabilitation Act of 1968 and the Drug Abuse Treatment Act of 1968. Both were amendments to the Community Mental Health Centers Act of 1963 and were designed to encourage Community Mental Health Centers to include components for the treatment of alcoholism and drug abuse.

.. In 1969 Senator Harold Hughes of Iowa took office. Within 3 months he had been named chairman of the Special Subcommittee on Alcoholism and Narcotics. Through a series of hearings in several cities, he developed the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act which was signed into law in December 1970. This Act upgraded the alcoholism component of NIMH to Institute status; and designated the new institute as the focal point of Federal efforts in alcoholism; created the National Advisory Council on Alcohol Abuse and Alcoholism (NIAAA); and authorized block grants to states, project grants and contracts to public

and private organizations, institutions and individuals. This Act also required that alcohol abuse and alcoholism treatment programs be available to all federal civilian employees and military personnel.

.. The Drug Abuse Office and Treatment Act of 1972 established, for a 3-year period, the President's Special Action Office for Drug Abuse Prevention. The mandate of the office was to coordinate all Federal drug abuse prevention and treatment functions and to develop a comprehensive Federal strategy to combat drug abuse. The office was instructed to give special emphasis to dealing with problems related to drug abuse and criminal activity. In carrying out its functions the office received a substantial appropriation for grants and contracts in this area. The Act also established a National Advisory Council for Drug Abuse Prevention to assist the Director of the Special Action Office in developing policies, objectives and priorities for all federal drug abuse prevention functions. Among other things the Act prohibited any hospital supported in any way by Federal funds from refusing admission or treatment to drug dependent persons who were suffering from emergency medical conditions. In addition to authorizations for special contracts and grants, the Act authorized a substantial appropriation for formula grants to the states for activities relating to drug abuse prevention and treatment.

.. At the time that SAODAP was created there was also authorized the establishment of the National Institute on Drug Abuse. The Institute, which came into being about a year prior to the termination

of the Special Action Office, assumed many of the responsibilities of that office and, in addition, responsibilities in the area of drug abuse prevention and treatment commensurate with the responsibilities performed in the area of alcoholism by NIAAA.

.. The Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) was created by legislative act in 1974. Within ADAMHA are three separate and organizationally equal institutes - The National Institute on Alcohol Abuse and Alcoholism; The National Institute on Druge Abuse; and the National Institute of Mental Health. By this action, Congress recognized the growing problem of alcohol and drug abuse; the need for high level and independent activity of the federal agencies with primary responsibility in these areas; and the need for close coordination between the efforts in mental health, drug abuse and alcoholism.

The primary need in both alcohol and drug problems in the early years of federal programming was for treatment services. Thus some 95,000 drug abuse treatment slots have been federally funded since 1972, and a large portion of the NIAAA budget has been utilized for staffing grants and other treatment services.

More recently the federal emphasis has been turning to an examination of the quality of treatment, and more attention is being given to prevention efforts and research.

The recent emphasis on establishing alcohol and drug abuse programs through the vehicle of Federal project or staffing grants has assumed that these grants would act as start-up money, to be replaced by other funds.

However, alternative funding for these purposes has not been readily obtainable. In view of the prospect of declining federal funds for projects or treatment staff, the recent emphasis on revenue sharing, and recent proposals for Health Revenue Sharing and National Health Insurance, it is imperative that those interested in alcohol and drug problem services understand thoroughly the various existing funding programs and the several proposals under consideration by Congress and the Executive Department so that they can identify alternative sources of funding for these services, as well as the impact various funding mechanisms may have on service delivery. To this end, several persons, representing various organizations, established the Funding Task Force of the North American Congress on Alcohol and Drug Problems at the initial meeting of that body which was held in the city of San Francisco, December 12-18, 1974. More than 20 organizations are represented on the Task Force which is comprised of four components - the West Coast Group, the Mid-west Group, the Southwest Group and the East Coast Group. Each group has held a series of meetings during 1975 and addressed various issues. The National Institute on Drug Abuse, which has sent observers to each of the East Coast group meetings, contracted with the Alcohol and Drug Problems Association of North America, the permanent Secretariat of the North American Congress, to develop this report of the Funding Task Force findings.

The initial purpose of the Funding Task Force was to serve as a vehicle for program oriented individuals to advise federal representatives about the impact of various funding problems and funding sources on programs. The Task Force does not consider itself necessarily representative of the field;

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it is a loosely-structured, provider-oriented group which has invited input and participation by any interested person or group. This paper discusses funding issues identified through this process.

Primary responsibility for the drafting of this document has been assumed by the Task Force Steering Committee, composed of the Chairpersons of the four Regional Groups and a few other individuals.

The focus of this document is to identify funding problems identified by any component of the Task Force and to illustrate these problems with the specific experiences of programs represented in the group. We believe these experiences, although unique, are illustrative of generic problems.

II. DRUG AND ALCOHOL ABUSE PROGRAMMING

A. Continuity of Care Process

It is important that any funding mechanism for alcohol and drug services cover a broad enough spectrum of services and service providers to insure that individual patients or clients are provided with a continuum of care which is adequate and appropriate to their needs. Such care may include a combination of inpatient hospital services, direct medical care, residential care in various sheltered environments, counseling, job training and placement assistance, family assistance and aid in dealing with various life problems. Such care may be given by a variety of personnel, some of whom lack traditional academic credentials. Funding must be set up so that care is determined on the basis of individual needs and not on the basis of what care is covered by the financing mechanism. Funding poses a problem in providing the appropriate continuum of care, both generally and for individual patients, in that funding mechanisms tend to respond to a particular organization or to particular service providers, regardless of actual

service needs. Also, each funding source has different policies, standards, and requirements, but provides no funds to assist programs in meeting these various standards.

Continuity of care is also important because alcohol and drug problems are so intertwined that in many cases one leads to another. There are many ex-addicts who are alcoholics and vice-versa. Moreover, abuse of alcohol and other drugs often leads to other health problems such as cirrhosis of the liver, hardening of vessels, hepatitis, and so on. Services should be structured so that treatment for all problems related to alcohol or drug abuse can be provided or arranged for at a central point.

A key issue, in this regard is the question of whether alcohol and drug abuse efforts should be under the same administrative umbrella. Some 29 states now have combined State-level "substance abuse" agencies, and there is some strong support for such an administrative structure. Many in both fields agree that alcoholism and drug addiction have much in common, and that persons addicted to alcohol and drugs could be treated either in the same program or in programs that are very much alike. Some programs are already using the same staff and treatment methods with both alcoholics and polydrug abusers. In some cases, alcoholism programs have opened drug units.

However, some persons in both the drug abuse and alcoholism fields are seeking to prevent such a combined program on the basis that the diverse backgrounds and ages of the abusers would prevent a harmonious, therapeutic rehabilitation effort. Some feel that the "substance abuse" concept is a poor one, for both the drug abuse and alcoholism fields, and from both the programmatic and funding points of view. They feel that merger would decrease the identity of both fields, but especially of the field of alcoholism - an identity won only after a long and hard battle - and would

therefore likely cost it the support of some of its constituency. This is an especially important consideration since the field's large and voluntary constituency has been one of its strongest assets.

Certain major goals are shared by programs for alcoholism and programs for drug addiction. Both strive for an interruption of addictive behavior, improved health, adequate coping ability, resocialization, employment, reduction of crisis in the patient's life and, finally, elimination of drug misuse, including the misuse of alcohol.

Where alcohol and drug abuse programs are separate, it is often difficult to transfer a person from a treatment program for heroin addiction to another program for alcoholism, should the patient develop that problem. This is important because a significant number of narcotic addicts become involved in the abuse of alcohol at some point in their addictive history, and an adequate response to such individuals requires treatment of both problems. Thus, programs which treat multiple addictions, and/or policies which encourage easy transfer from drug to alcohol programs, may well be desirable.

One approach which might improve cooperation between drug and alcohol service agencies would be cross-training of staff and placement of separate detoxification facilities in the same physical location.

Funding sources generally are divided between sources, usually referred to as categorical funds which fund complete program operations, and sources, generally known as third party payers, which reimburse particular programs for services rendered to individual clients. While there is presently a great deal of emphasis on the need for drug abuse treatment programs to utilize third party payments, it is important, in the context of care, to

understand that third party payers maintain artificial payment categories which are essentially not client-oriented. Moreover, third party payers have various policies and standards but provide no mechanism for funding programs to assist them in meeting these standards.

For programs which have previously been funded through grants or other non-reimbursement mechanisms, a switch to financing through third party payments poses cash flow and other problems. These problems are likely to be especially severe with respect to street programs or other programs which are highly responsive to client needs and which are not structured to conform to traditional provider orientations. These programs may well lack the management expertise or other sophistication to deal with the financial intricacies of funding a program through third party payments. Moreover, third party payment funding assumes that services and facilities are available and operational and does not provide a mechanism for the development of new facilities or the capitalization of physical plants.

It is a concern of this Task Force that a growing percentage of total program funding is being used to meet overhead requirements, at all levels of program administration, rather than to the direct provision of services. The development of detailed standards and qualifications for payment for services may be valid in terms of controlling the quality of such services. Unfortunately, however, many innovative programs, which offer important and effective services, cannot function within the classic health care mechanism. Consequently, care must be taken to assure that the need for developing payment standards is balanced against the need to provide a full spectrum of services to allow providing the appropriate continuum of care in individual cases. To this end, it is important to synchronize funding

mechanisms to eliminate, insofar as possible, conflicting policies and regulations and to insure the availability of adequate financing for the full continuum of necessary alcohol and drug abuse services. Funding must be available for traditional and non-traditional services, including services which cannot be financed on a client reimbursement basis and services which do not fall within the medical model.

B. Components of Care

1. Consultation and Education, Prevention: This category includes services aimed at individuals and entities involved with alcohol and drug abuse programs in order to develop effective alcohol and drug abuse programs, promote coordination of services and increase awareness among citizens of alcohol and drug abuse problems and resources.

2. Outreach, Assessment, Referral

3. Crisis Management (Detoxification)

   a. Residential

      1) Hospital

      2) Non-hospital

   b. Non-residential

   Crisis management is defined as activities associated with addressing an emergent or immediate situation perceived by a client as being threatening to himself or others. This category includes activities generally identified as protective services, subacute detoxification, and acute detoxification.

4. Primary Treatment and Rehabilitation

   a. Residential

      1) Hospital

      2) Non-hospital

   b. Non-residential

Primary treatment and rehabilitation is defined as a set of intensive activities, of limited duration, designed to provide the person in treatment with a positive substitute or alternative to addiction, dependency and associated behavioral activities.

5. Transitional/Aftercare/Extended Care

   a. Residential

      1) Hospital

      2) Non-hospital

   b. Non-residential

Transitional/aftercare is defined as a set of on-going supportive activities, including professional and self-help programs, designed to maintain behavioral change.

Halfway houses and other similar programs may fall into this category, but, depending on the program and purpose of the activity, they may also fall within crisis management or primary treatment and rehabilitation.

6. Supportive Services

Supportive services are services provided to the client as part of on-going care, either as a direct part of a program or as "ancillary" services arranged for by the program, such as

vocational rehabilitation, legal services, education, income maintenance, and family counseling.

The above components of care and the accompanying definitions were developed by the Steering Committee as a reflection of the components of care which should be available to enable the provision of adequate and comprehensive services for individual alcohol and drug abusers. These components of care and the accompanying definitions reflect the Committee's view of what should be rather than what is.

In arriving at these definitions and components the Committee reviewed various other suggested organizations for alcohol and drug treatment services delivery, including the categories of care listed in the JCAH standards for accreditation of alcohol treatment programs and the proposed JCAH standards for the accreditation of drug treatment programs. The Committee felt, in reviewing these categories, that they tended to be provider-oriented and medically oriented rather than client-oriented. Thus, the Committee attempted to take a different perspective and identify the components of care necessary to provide adequate client services rather than organizing the necessary service elements to comply with the often arbitrary definitions used by funding sources. As a general matter the Committee believes that care components 1 and 2 (Consultation, Education and Prevention and Outreach, Assessment, Referral) should be program funded. Once a client enters program component 3 (Crisis Management), and thereafter, throughout the treatment sequence, it should be possible to track individual clients so that funding can be on a reimbursement or client basis. Although all supportive services (component 3) could technically be funded on a client reimbursement basis, it may well be that certain such services should be

programmatically funded so that the provision of the service is not disrupted by the need to determine client eligibility for reimbursement from various sources.

C. Relationship of Service Categories to Funding Mechanisms

The matrix following this page has been filled in by the Mid-West Task Force to indicate sources of funding available, in that area, for various program components. A similar matrix could be developed for each state and most localities, based on state or local funding realities. Development of such a matrix, perhaps more than any other single mechanism, illustrates graphically the actual funding situation in a given area and the extent to which specific care components and the full spectrum of care are supported by: a) particular funding sources, and b) the range of available funding. An accurate matrix provides an excellent mechanism for alcohol and drug programs to identify gaps in their ability to obtain funding for comprehensive prevention, treatment and rehabilitation programs.

III. CURRENT FUNDING SOURCES

A. Public Funds - Provider or Program Oriented

1. Federal Project Grants

a. Eligibility and Requirements

Categorical grants are available to support public and private programs aimed at particular disorders, i.e., alcohol, drug abuse. Categorical project grants are normally aimed at helping a project get started; they are not available for permanent funding. Often categorical grants require alternate funding ("match") for an increasing proportion of the project budget in each succeeding year. The greatest worry of most categorical grant recipients is the grant's life expectancy.

b. Limitations

Categorical funds are not strictly limited in terms of allowable services, however, certain costs are considered unallowable costs under federal regulations. These include social activities and entertainment for clients, which are beneficial for their rehabilitation.

c. Problems

Frequently programs have funds from a number of categorical grant programs, yet the regulatory agencies involved are often unable to agree on policy matters. This poses serious difficulties for programs who must try to comply with conflicting requirements or risk loss of funds. Also, many questions come up during the year to which no agency will give a definitive answer.

FUNDING MATRIX*

Key:
A = Primary Responsibility
B = Supplementary Response
C = Desireable Response

	Categorical Grants (federal)	Formula Grants (federal)	Medicaid	Medicare	Title XX	Supplemental Security Income	State Funding	Local Funding	Funding through CHAC Legislation	Dedicated Funds	Revenue Sharing	Vocational Rehabilitation	LEAA	Federal Purchased (DOD, VA, CHAMPUS)	Health Insurance	HMO's	Origin of client fees	Food Stamps
Consultation/Educ./Preven.		A			B			B	A									
Outreach, Assessment & Referral - Intervention	A	B			A			B				C						
Crisis Management																		
Residential					A		A	B					A					
Non-Residential	B				A		A	B										
Primary Treatment/ Rehabilitation																		
Residential			A	A	B			B				C	A	A	A			
Non-Residential					A			B				C	A	B	B			
Extended Care																		
Residential	B				A		A	B				C	B					A
Non-Residential					A		A	B	B			C	B					
Supportive Care	A					A					A	B						A

HOME

CAPITAL IMPROVEMENTS

* Matrix reflective of experience of Mid-West Task Force on Funding

In many cases funding for individual programs is dependent upon having a certain number of clients in the program. This means that programs may lie about the number of clients in treatment or - worse - may gear the treatment program to attract clients by such mechanisms as excessive doses of medication, payment to clients and the like.

As the categorical grant progresses through its funding period, a program must continue to provide comprehensive services to an equal or increasing number of clients as the federal portion of the grant is decreasing and the non-federal is supposedly increasing. This creates many problems, especially during an inflationary period where there is much unemployment and local communities are reluctant to provide any services or give any funds to be used as matching funds.

d. Recommendations

1) There should be regional and national seminars on various topics of concern to programs. Regional programs should be focused in areas with severe addiction problems. These seminars should be conducted with an extensive period of study and learning and not as conferences.

2) There should be an on-going mechanism for exchange of experience among programs.

3) A number of issues concerning categorical grant funding need exploration. These include detailed study of in-patient and out-patient costs and allowable matrix costs; use of government land for federally funded programs, i.e., residential centers, therapeutic communities; and dealing with revenue sharing.

2. Formula Grants

a. Eligibility and Requirements

Both NIAAA and NIDA, in the alcohol and drug abuse areas respectively, administer formula grant programs whereby each state receives a pre-established portion of a national allocation upon receipt and approval of a State Alcoholism or Drug Abuse Plan. Approval for funding is handled by the NIAAA Regional Offices and the Community Assistance Division of NIDA. The Governor of each state is required to designate a single state agency as being responsible for the preparation and implementation of the alcohol or drug abuse plan.

According to P.L. 91-616 the purpose of the alcohol formula grant program is to assist states in "planning, establishing, maintaining, coordinating, and evaluating projects for the development of more effective prevention, treatment, and rehabilitation programs to deal with alcohol abuse and alcoholism."

P.L. 92-255, § 409(b) specifies that drug abuse formula grants, for which $45,000,000 was authorized but only $35,000,000 appropriated during FY 1975, are to be used:

> "(1) for the preparation of plans. . .
>
> (2) for the expenses (other than State administrative expenses) of (A) carrying out projects under and otherwise implementing. . . this section, and (B) evaluating the results of such plans as actually implemented; and

(3) for the State administrative expenses of carrying out plans approved by the Secretary. . ."

These funds are, by volume, the fourth most important source of support for drug abuse programs.

b. Limitations

None

c. Problems

There is no national mechanism for coordination of alcohol and drug abuse planning at the local or state level. Even if the State Agency for Alcohol and Drug Abuse is combined there is separate accountability for formula grant funding.

d. Recompendations

1) There should be a definite mechanism to insure local input into the process of formula grant planning and spending.

2) Steps should be taken to enable states with joint alcohol and drug planning to obtain approval of a joint plan from a central authority.

3) The Alcohol, Drug Abuse and Mental Health Administration, and its member Institutes, should address the problems, policies and procedures involved in joint planning for alcohol and drug abuse services, and for these services combined with mental health, and should issue a clear policy statement in this regard.

3. Local Funding

a. Eligibility and Requirements

Local funds are an important element in funding a comprehensive system. The amount of local dollars appropriated for alcohol and drug programs cannot easily be documented (although a recent study by the National Association of State Drug Abuse Program Coordinators found local funds to be the third largest total funding source for drug programs), but may very well exceed federal appropriations in these two areas. In addition, local funding, for matching purposes, is often a prerequisite to the accessibility of other funding. Local funds allow a program to address the full range of a client's needs and problems, with a minimum of counter-productive labeling, and provide the most program flexibility of any public funding source. While there are often restrictions and constraints placed on programs utilizing these funds, they are imposed by local funding agencies and may be removed or modified with a minimum of difficulty. Funding parameters tend to be much more individualized than funding from other sources.

b. Limitations

Because of the extensive demands made upon cities, counties, and school districts, the ability of these local governments to bear responsibility for funding drug and alcohol programs is limited. The only revenues available to the units are those raised from local property or other taxes, and most such revenues are required for support of mandated programs or activities or to serve as local match for State and Federal

funds. The limitations on local tax bases greatly restrict the extent to which such funds can be expected to fully support existing local programs or serve as a funding mechanism for new efforts.

4. State Funding

a. Eligibility and Requirements

States provide funding for a broad range of services and programs aimed at dealing with drug abuse and alcoholism. According to a recent study by the National Association of State Drug Abuse Program Coordinators, state funds are the most significant source of support in the drug abuse area, with states appropriating $325,077,825 in FY 1976. Of this amount $197.2 million was spent for direct treatment services. Thus state efforts in the treatment area exceed NIDA efforts ($121 million) and probably all federal efforts (estimated at $207.8 million) aimed at providing direct treatment services. Additionally, states are spending $176.6 million for community assistance, much of which is treatment related, and $3.2 million for rehabilitation services. In drug abuse prevention, the study indicated that the states are spending more than twice as much as the Federal Government; state corrections departments spent $48.9 million for such services as compared with $12.2 million spent by the Federal Bureau of Prisons.

b. Limitations

State and local governments are unable readily to increase taxes to obtain additional funds for alcohol and drug abuse programs.

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State funding flexibility may be limited by the imposition of federal requirements concerning service priorities, match, etc.

c. Problems

Although the Federal Government made a commitment during the years 1973 and 1974 that the level of 95,000 federally-funded treatment slots would continue to be supported without additional cost to other levels of government, this level of treatment slots has actually been maintained by forcing state and local governments to increase match rates above the amounts called for by existing grants and contracts. For FY 1976 state and local governments have been required to raise $15 million in order to maintain the federally-mandated treatment slot level because cutbacks in the federal budget made that budget inadequate to support this number of treatment slots. These changes in the required match ratio have forced state governments either to increase the funding available for drug abuse programs or to cut back the level of such services available. Even where states have been able to increase their drug abuse program budgets to meet increased federal match requirements, the fact that such increased match requirements were arbitrarily imposed has significantly decreased the ability of state governments to utilize their drug abuse program funds in a flexible way to insure that their programming is geared to actual drug abuse service needs in individual states.

d. Recommendations

1) Federal match requirements, both as to percentage and as to hard vs. soft match should be clearly stated and should remain constant, except where a change is Congressionally mandated.

2) The states should focus attention on the fact that they are the primary funding source for drug abuse services, and they should be appropriately represented in any federal discussions on drug abuse needs, priorities, and funding.

5. Revenue Sharing

a. Eligibility and Requirements

Under the State and Local Fiscal Assistance Act of 1972 $30.2 billion is available to be distributed among units of general government (states, cities, counties, towns, townships, Indian tribes and Alaskan native villages) between Jan. 1, 1972 and Dec. 31, 1976.

The money is allocated by a formula based on population, per capita income and tax effort.

Revenue sharing makes possible a continuation or expansion of programs without commensurate tax increases. It is a potentially important source of funding for alcohol and drug abuse programs.

There must be regular reports to both the public and the Federal government on how revenue sharing funds are utilized. Additionally, each recipient of shared funds must involve the public in deciding how the funds are to be spent.

Funds may be used for capital expenditures of any type or for operating and maintenance expenses in eight specified "priority" programs. These priority categories include public safety, environmental protection, public transportation, health, recreation, libraries, social services for the poor or aged, and financial administration. Shared funds may be used to supplement (but not match) other Federal grant funds within the priority areas.

Use of funds within the allowable categories is entirely dependent on local needs. Revenue sharing has made it possible for some local areas to absorb cuts in Federal programs without cutting services or increasing taxes.

Revenue sharing offers a source of funding which enjoys many of the benefits described in the subsection dealing with local funding. Such funds may be used by cities and counties to fund a wide variety of drug and alcohol programs or general community programs which deal with drug and alcohol abuse within a community context aimed at improving the total quality of a client's life. While some jurisdictions restrict the use of revenue sharing to capital expenditures, or limit the categories which may be served to the poor, the aged, or citizens disadvantaged in some other measurable manner, even the use of such criteria may often be comfortably accommodated within a broadly based community effort aimed at dealing with alcohol and drug problems.

b. Limitations

There are no statutory limitations that affect alcohol and drug programs. Many local leaders are, however, unaware of or

unsympathetic to the need for alcohol and drug abuse services. This acts as a practical limitation on the availability of such funds for these services.

Also some localities have adopted a policy of only providing revenue sharing funds to programs that can demonstrate an ability to obtain other financing.

c. Problems

A primary drawback of revenue sharing is that local officials are always unsure as to how a program so supported is to be funded in future years. Any program which provides needed services to a community will develop a political constituency, and, should revenue sharing funds available to a local government diminish or vanish, -- a possibility totally outside the control of a local elected official -- great pressure will probably be brought to bear on the local official to fund the program with local general fund revenues. Local political bodies are wary of such situation because of their potential impact on local tax rates.

A second concern is that revenue sharing may soon be subjected to categorical restrictions. If, for instance, any drug or alcohol programs funded with revenue sharing funds were required to adopt a medical model and treat their clients within either a public health or community mental health format, much of the flexibility of many existing programs would be destroyed. Local officials are also concerned that requirements of P.L. 93-641 and similar legislative regulations will greatly increase the overhead and bureaucratic nature of drug and alcohol programs.

d. Recommendations/Program Experience

There is a wide variety of program experience with Revenue Sharing funds, although it appears that not a great deal of such funding is going into human services programs. However, the overall impact is favorable in that revenue sharing may free other funds for human service programs.

In Orange County, California there is a requirement that 25% of revenue sharing funds go to human service programs, with a priority for programs which can demonstrate a cooperative arrangement with cities.

Revenue sharing has now developed its own traditions, so that funding is likely to go to programs or areas which were previously funded.

6. LEAA

a. Eligibility and Requirements

The Law Enforcement Assistance Administration (LEAA) is a potential source of both funding and technical assistance. Two sources of funds are available -- block grant funds allocated to the state planning agencies and discretionary funds awarded directly by LEAA or one of the ten regional offices. Technical Assistance is available through organizations receiving contracts from LEAA to provide on-site consultation and technical services.

The bulk of the funds are allocated to the State

Planning Agency (SPA) in each state. Local planning units must submit plans annually to the SPA for incorporation into a state comprehensive plan. The state plan is approved by LEAA. Proposals must be submitted through local planning units for funding. State policy on allocation of funds should be investigated first, since some states do not fund alcoholism or drug abuse programs. Discretionary grant applications must also be endorsed by the SPA before approval by LEAA. Local planning units should be contacted before applying for discretionary grants. Discretionary funds break down into two types--- Part C, which amounts to 15 percent of the total block grant category, and Part E, a category earmarked in the Crime Control Act of 1973 for corrections programs and facilities. The federal legislation specified that grants awarded under Part E "provide necessary arrangements for the development and operation of narcotic and alcoholism treatment programs....."

LEAA funds are generally short term, start-up funds.

b. Limitations

Generally programs funded through LEAA must provide services to people who are involved in the criminal justice system. Assistance may also be available to prevent future criminal justice activity.

LEAA will often not fund alcohol and drug treatment services.

c. Problems

Problems here are the same as with project grants. It is difficult to pick up the costs of LEAA started programs because of the nature of the built-in overhead. It is difficult to pool LEAA funds with other funds.

Variation among regional interpretations is a particular problem with LEAA.

d. Recommendations

1) There should be better integration, at all levels, among federal programs.

2) Funding requirements should be more flexible.

3) Pooling of funds from various federal programs should be encouraged and made easier.

7. Juvenile Justice Delinquency and Prevention Act*

a. Eligibility and Requirements

The Act (P.L. 93-415) contains broad Federal initiatives for primary prevention and early intervention, with authorizations for block grants to State and local governments as well as grants to public and private agencies for developing juvenile justice programs — with special emphasis on deinstitutionalization, diversion, and prevention. With respect to drug abuse the Act specifically states that "existing programs have not

* Information on Juvenile Justice Delinquency and Prevention Act taken primarily from the November 1, 1975 issue of the publication of the National Association of State Drug Abuse Program Coordinators

adequately responded to the particular problems of the increasing numbers of young people who are addicted to or who abuse drugs, particularly non-opiate or polydrug abusers."

The major directives to LEAA in administering the Act include:

- To make formula grants to State and local governments. (These funds are allocated annually among the States under a formula based on the relative population of people under the age of 18. In order to be eligible for funds States are required to submit yearly comprehensive plans.)
- To coordinate the overall Federal policy regarding juvenile delinquency.
- To develop a discretionary grant program for special emphasis and demonstration programs. (LEAA retains from one-quarter to one-half of the funds appropriated under the Act for demonstration projects.)
- To provide technical assistance to Federal, State, and local governments, agencies, organizations, and individuals.
- To conduct research into juvenile delinquency issues and to conduct evaluations of juvenile justice programs.

At least 25% of funds available under the Juvenile Justice Act must be spent for discretionary purposes. The Juvenile Justice Office has developed the following priorities for discretionary funding:

- Removal of status offenders from detention and correctional facilities;
- Diversion of offenders from the juvenile justice system;
- Reduction of serious crime committed by juveniles; and
- Prevention of delinquency.

At least 75% of the State's formula grant funds must be used for advanced techniques, to include:

- Community-based programs and services for the prevention and treatment of juvenile delinquency through the development of foster-care and shelter-care homes, group homes, halfway houses, homemaker and home health services, and other designated community-based diagnostic, treatment, or rehabilitative services;
- Community-based programs and services to work with parents and other family members to maintain and strengthen the family unit so that the juvenile may be retained in his home;
- Youth service bureaus and other community-based programs to divert youth from the juvenile court,

or to provide counsel, or provide work and recreational opportunities for delinquents and youth in danger of becoming delinquent;

- Comprehensive programs of drug and alcohol abuse education and prevention and programs for the treatment and rehabilitation of drug addicted youth, and "drug dependent" youth.
- Educational programs or supportive services designed to keep delinquents in elementary and secondary schools or in alternative learning situations.
- Expanded use of probation and recruitment and training of probation officers, other professional and paraprofessional personnal, and volunteers to work effectively with youth.
- Youth-initiated programs and outreach programs designed to assist youth who otherwise would not be reached by assistance programs.

b. Limitations

Available only for services or programs aimed at youth, but within this area there is a broad latitude for services.

c. Problems

In terms of delinquency prevention funds no money is available for any program within a state unless the state, and all its components agree to deinstitutionalize status offenses. As a result, many states are declining to participate in the program.

8. CMHC (Community Mental Health Center)*

a. Eligibility and Requirements

The community mental health centers program was established by Congress in 1963 to make a wide range of mental health care services readily available to residents of a given geographic area regardless of ability to pay.

Services range from prevention to inpatient care, but the accent is on ambulatory care which facilitates an easier adjustment after treatment and permits the individual to remain a functioning, productive member of society while receiving treatment.

While the centers are intended to develop effective community alternatives to long-term institutional care of the mentally ill, they have a number of other responsibilities which make them unique in terms of program focus among mental health programs.

Unlike most federal programs, CMHCs have responsibilities which go far beyond the delivery of direct health care services to those in need.

First, each CMHC is responsible for serving a specified geographic area, termed a catchment area, and for providing a full range of services to all residents in that area, including preventive services, early intervention and emergency services.

Each center must either develop a full range of mental health services, or ensure that such services are

* Information in this section taken from the November 17, 1975 issue of the newsletter of the National Council of Community Mental Health Centers

available in the community through other agencies which affiliate and cooperate with the CMHC. These services include various outpatient therapies, emergency services, partial hospitalization, transitional living arrangements and other alternatives to institutional care and after-care services as well as 24-hour inpatient services. In addition, specialized and comprehensive programs to serve the needs of population groups with special problems must be established. These include programs for children and the elderly and, if no alternative services are available in the community, programs for alcoholics and drug addicts and abusers. P.L. 94-63 reaffirms the responsibility of a CMHC to provide alcohol and drug abuse services.

A vital part of any CMHC program is its consultation and education service -- the preventive, early intervention and health education program. Through these programs, centers develop consultation services for various community agencies -- schools and other educational institutions, police and correctional agencies, welfare departments, social service agencies, and various health professionals. Consultation from the center enables the staff of these other agencies to better handle problems arising from mental or emotional disturbance, to understand the services of the center and to more appropriately refer individuals in need of treatment to the CMHC. This greatly facilitates early intervention. Through these consultation programs and through various

education programs operated by the centers' agencies, providers and individuals are better able to understand and recognize mental health problems and to deal with them.

Two other important aspects of the CMHC's role are the accessibility of services and continuity of care for patients under care. CMHCs are charged with ensuring that the full range of required comprehensive services are both available in the community and accessible to all parts of that community in terms of their physical location (ease of travel to the facilities, etc.) and other barriers to service arising from socio-economic factors. Services are to be available to all, regardless of their ability to pay.

Fragmentation and lack of coordination between services is a major problem in the delivery of human services. CMHCs are charged with ensuring that all services required under the Act are provided, either by the center or through agencies which have written affiliation agreements with the center. This ensures continuity of care for patients and prevents individuals from "slipping through the cracks" — an all too common problem when no formal linkage exists between services in a community.

CMHCs are also required by law to ensure that these required mental health services are properly coordinated with other related health and social services in the community.

b. Limitations

There is no mechanism for payment by a CMHC to other providers of alcohol and drug abuse services, other than a formal affiliation agreement, approved by NIMH.

c. Problems

Many CMHC's do not offer alcohol and drug treatment services directly, nor do they have affiliation agreements with alcohol or drug treatment programs in or near their catchment areas. Even where such services are offered, it is often by staff without specialized alcohol or drug abuse training or experience.

Current federal third party payment programs for health services -- Medicare and Medicaid -- do not facilitate support for services provided through community mental health centers. Although a number of centers are able to participate under these programs in many instances they are inappropriately classified (as psychiatric hospitals) or receive reimbursement for services provided by individual members of their staff based on a fee-for-service rate. Provider reimbursement through Medicare, for instance, is not available for about 80% of CMHCs.

The cause of the problem is the emphasis under Title XVIII, and to a lesser extent Title XIX, on services provided through traditional institutions (hospitals, nursing homes) and through private practitioners. The centers program, which has grown in scope to a substantial program at this date, was not operational when Title XVIII was first written. No amendments have yet been made to include the centers because federal categorical funding was available.

Now that federal categorical funding is terminating for a number of centers which have reached the end of their eight years of federal support, the issue of Medicare coverage has become critical, and the National Council of Community Mental Health Centers (NCCMHC) has proposed amendments to Title XVIII to enable community mental health centers which meet federal standards to participate as providers and to receive reimbursement for mental health services provided under appropriate conditions. This would include reimbursement for all services provided by mental health professionals, not only the services provided by or under the direct supervision of physicians, as under the current law.

d. Recommendations

1) Any CMHC which does not offer alcohol and drug treatment services, or have a formal affiliation agreement with an alcohol or drug treatment program for such services, should be required to make an affirmative showing of lack of need for such services before obtaining federal funds.

2) CMHC staff providing alcohol or drug treatment should have specialized training.

3) Third party payers should pay for alcohol and drug abuse treatment provided in a CMHC or through a formal affiliation agreement.

9. Dedicated Funds (Earmarked taxes)

These taxes are generally imposed on the sale on alcoholic beverages, and "earmarked" as funding for prevention or treatment

programs. Although a similar program could, hypothetically, be established in the drug area, it has not, this far, been done.

The arguments below are those most frequently made on both sides of the issue, and do not, necessarily, reflect the views of the Steering Committee.

a. Arguments For

1) Dedicated funding is self-sustaining and self-generating, and is capable of some expansion even in periods when it is not feasible to increase general taxes.

2) Dedicated funds are available for a full range of alcohol services, not just services based on the medical model.

3) A special tax is generally less regressive than a general tax.

4) Earmarked taxes are a tax shift (from general sales and income taxes) rather than a tax increase. Since a small minority of consumers consume the majority of alcoholic beverages, and since this group is the at-risk population for alcoholism, it is appropriate that they should bear the cost of alcohol services.

5) The tax can be directly related to the amount of alcohol purchased and consumed, which is clearly a significant measure of abuse.

6) At least in California, surveys have shown that tax payers favor higher alcohol taxes to support alcoholism programs (46% were in favor, 45% opposed, 9% undecided), while there is opposition to a general tax increase to finance such services.

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b. Arguments Against

1) Alcohol is not the cause of alcoholism and it is therefore unrealistic and unfair that funds for dealing with this condition should come from earmarked taxes rather than from the general revenue.

2) To earmark taxes for alcoholism effectively removes this condition from the general health area and establishes it, in the public mind, as a condition that is somehow different than other health problems.

3) Earmarking gives undue emphasis to the difference between users and non-users.

4) Earmarked taxes are not flexible enough to deal with the alcoholism problem and, since the problem does not limit itself to product sales the base of support for treatment programs should not be so limited.

5) Public health problems should be addressed through general tax revenues.

6) There is a danger in tying public programs to specific taxes. If anticipated revenues do not materialize, serious budget deficits can result. Budget surplusses resulting from earmarked taxes may lead to make-work programs and wasted revenues.

7) Dedicated funding tends to shelter public agencies from annual legislative review of program needs.

8) The use of dedicated funds, which are sheltered from

annual review, tends to create narrowly drawn vested interests.

9) Earmarking of taxes is a denial of the claim that alcoholism is a public health problem which can be treated in the same way as other illnesses. In effect earmarking taxes provides alcohol programs with special and preferential funding treatment.

10) Dedicated taxes mean that those who do not abuse alcohol are paying for the treatment and rehabilitation of those who do.

c. Program/State Experiences

In Alabama where an alcohol tax was imposed to finance mental health care none of the resulting funds have gone for alcohol treatment or prevention programs.

In South Carolina the special tax is returned directly to the county in which it was generated.

B. Public Funds - Client Oriented (continued next page)

1. Medicaid

a. Client Eligibility

Medicaid is a program which provides federal assistance to the states in meeting the cost of certain types of medical care to the needy. Each state program has considerable flexibility in deciding who is eligible for Medicaid financial assistance, although all states are required to provide such assistance to the categorically needy who include individuals receiving aid under either the AFDC or the SSI programs. States may elect to provide assistance to non-categorically related needy persons or to the medically indigent. The medically indigent are generally those persons who do not qualify for categorical public assistance programs because of the level of their income or resources, but whose income and resources are inadequate to meet the costs of their medical needs.

(Each state program is different, thus the California experience is cited as unique but illustrative.) In California's Medi-Cal program both the categorically needy and the medically needy are eligible for Medi-Cal assistance. Alcoholism and drug abuse are not factors in determining Medi-Cal eligibility. California's program is divided into two parts called Reform Medical and Short-Doyle Medical. Reform Medical is generally the reimbursement mechanism for private practitioners, whereas Short-Doyle Medical is focused on program funding.

b. Provider Status

Each state has its own mechanism for according provider status to a program, facility, or individual who delivers services

eligible for Medicaid reimbursement. In order to be reimbursed a provider must have complied with whatever procedures are laid out in the state Medicaid plan and regulations. A provider must be officially accorded provider status to be eligible for Medicaid reimbursement. Generally the program is oriented to financing traditional medical care so that provider status is most likely to be accorded to physicians, general hospitals, specialized hospitals which meet JCAH standards, hospital outpatient services and organized outpatient clinics. Few states have provisions for according provider status to programs which are not patterned on the medical model. Also, even where services are given in a medical model program, direct medical services are more readily reimbursable than are rehabilitation services.

c. Services Covered

All states participating in Medicaid are required to cover the following services when they are rendered to individuals participating in the Medicaid plan:

1) Inpatient hospital services except those in an institution for tuberculosis or mental diseases.

2) Outpatient hospital services.

3) Services in a skilled nursing home, except an institution for tuberculosis or mental diseases, for individuals over 21.

4) Laboratory and x-ray services.

5) Periodic health screening and diagnostic services to identify physical and mental defects for individuals under 21.

6) Physicians' services.

7) Home health services for certain categories of Medicaid recipients.

8) Family planning services.

A state Medicaid plan can impose limitations on these services. In addition to the required services a state may elect to offer a series of additional services which, as specifically relevant to alcohol and drug treatment, include clinic services, other diagnostic, screening, preventive and rehabilitative services, inpatient psychiatric services for persons under age 21, or over age 65, and any other medical or remedial care.

Again, there is wide variation among the states as to which services are covered. The state Medicaid plan for each state indicates what services are covered in that state. It is estimated that up to one-third of the states specifically exclude alcohol and drug abuse services from any Medicaid reimbursements.

In California, under the reform Medi-Cal program, a patient receiving alcohol and drug detoxification services in the psychiatric section of a general hospital is covered for up to eight days, regardless of the age of the client. Alcohol and drug detoxification which is provided in a psychiatric hospital is a covered service only for those under age 21 and over age 65. There is also an eight day limitation on this coverage. Reform Medi-Cal does not cover on-going treatment beyond the eight day detoxification period. Conversely, under the Short-Doyle Medi-Cal program patients are not covered for detoxification services, but alcohol and drug treatment services are covered, if a patient is receiving related psychiatric treatment.

Both reform Medi-Cal and Short-Doyle Medi-Cal provide coverage for outpatient methadone detoxification.

d. Legislative/Regulatory Restrictions and Conflicting Policies

1) There is no federal restriction against Medicaid coverage for a full range of alcohol and drug abuse treatment services. However, many states either directly limit coverage for such services or do not reimburse the kinds of providers who are most likely to provide such services.

2) There is an immense variation among programs from state to state. Because the program was set up to allow for state variation, there is no vehicle for encouraging the provision of services other than those specifically mandated.

3) Programs within particular states report great difficulty in getting consistent interpretations, within the state, as to the extent to which various drug and alcohol programs are eligible for reimbursement. An example of such internal policy conflicts is the opposite approach to detoxification and treatment coverage taken by the reform Medi-Cal and the Short-Doyle Medi-Cal programs in California.

4) There is no real fiscal incentive for states to recognize alcohol and drug treatment as covered services since the federal-state cost sharing in Medicaid is generally more expensive for a state than the match ratio required under categorical programs.

5) Although federal estimates are that $12 million in Medicaid funds were spent last year for drug abuse services, and probably more than that for alcohol abuse services, in most states federal reimbursements are not used for program expansion but rather to

reimburse state treasuries for state tax funds expended for these programs. Thus, even in states where Medicaid reimbursements are available for alcohol and drug abuse services, the availability of such payments may have no actual impact on the ability to deliver services.

e. Impact on Programs

Where alcohol and drug treatment services are eligible for reimbursement under the state Medicaid plan there is a tendency for the programs to structure themselves in whatever way will permit maximum reimbursement rather than in a way best suited to meet the needs of the community or the client.

Even when alcohol and drug abuse services are specifically eligible for reimbursement, a program cannot receive Medicaid funds until it has been recognized as a qualified provider. Moreover, reimbursements are not available except for clients who are Medicaid eligible in that state and who have actually registered and been through whatever process the state requires to receive a Medicaid card. And even for programs who have been accorded provider status and who are treating Medicaid covered clients, it is necessary for the program to bill Medicaid for services rendered. All of these factors mean that, for a program to receive Medicaid reimbursements, the program may have to develop additional administrative capabilities and to demonstrate that it complies with standards which it would not otherwise have to meet. This may result in a program being required to put a substantial proportion of its total budget into overhead costs rather than into the provision of the direct client services.

Because there is such a wide variation in state Medicaid programs, these programs are especially susceptible to political changes which may result from shifts in power in either the executive or the legislative branch of the state government.

f. Recommendations

1) Either the Medicaid program should be fully federalized in a way which insures that alcohol and drug abuse services are reimbursable or alcohol and drug abuse services should be included within the mandated services.

2) There should be uniform eligibility standards for Medicaid recipients.

3) Services covered in the alcohol and drug treatment area should be covered consistently regardless of the treatment setting in which the services are provided.

4) The feasibility of creating a mechanism for claiming reimbursement for services rendered to alcoholics or drug abusers without labeling the recipients of the services as alcohol or drug abusers, should be explored.

5) There should be a mechanism for states, localities and programs to share their experiences with Medicaid reimbursement and related problems.

6) Steps should be taken to make it easier for alcohol and drug abuse programs to gain provider status under Medicaid.

7) Medicaid reimbursements, and indeed all federal reimbursements which are tied to the delivery of particular services to individual clients, should be statutorily required to be utilized for program expansion rather than being utilized to

reimburse state treasuries for state tax funds which are appropriated for alcohol and drug abuse services, where this results in a decrease in the total amount available for such services. It should be a requirement that Medicaid funds, and those available through the other reimbursement programs, be used to increase the services available over and above the amount of service which was available for alcohol and drug abuse programs in whatever year is used as a base.

2. Medicare

a. Client Eligibility

Medicare provides assistance in the purchase of medical care primarily to those over 65 years of age. Also eligible are those under 65 and entitled to cash benefits under Social Security or railroad retirement because of disability for 24 months, those who have been SSI recipients for 36 months, and children, aged 18 or under (up to 22 if a full-time student), of a Medicare beneficiary. Alcoholism/Drug Addiction/Abuse has no bearing on Medicare eligibility.

b. Provider Status

The hospital or provider must be certified as participating in the Medicare program.

c. Services Covered

Covered services include all services which are directly provided by a physician. Up to $250 per year is available for outpatient psychiatric care. Service in an inpatient psychiatric hospital in the private sector is covered up to a lifetime limit of 190 days.

Medicare also covers services in a participating skilled nursing facility if the following five conditions are met:

1. Client has been in a hospital at least 3 consecutive days prior to transfer to a skilled nursing home.

2. Client is transferred to the skilled nursing facility because he requires care for a condition which was treated at the hospital.
3. Client is admitted to the facility within a short time (generally within 14 days) after he leaves the hospital.
4. A doctor certifies that he needs, and actually receives, skilled nursing or skilled rehabilitative services on a daily basis.
5. The facility's Utilization Review Committee does not disapprove the stay.

There are two major divisions of Medicare. One is Hospital Insurance for the Aged and Disabled which is authorized by Part A, Title XVIII of the Social Security Act. Hospital Insurance, frequently referred to as Part A Medicare, helps eligible individuals with the cost of hospitalization and related care. The other major division is Supplementary Medical Insurance for the Aged and Disabled which is authorized by Part B, Title XVIII of the Act. Medical Insurance, frequently referred to as Part B Medicare, helps eligible individuals with the cost of medical and surgical services by physicians. Also covered by Part B are some services in connection with a physician's treatment, e.g., X-ray examinations, laboratory tests, durable medical equipment, orthotic appliances and prostheses.

To be eligible for Part B Medicare payments, a mental health clinic must meet the Social Security Administration definition of a physician directed clinic and comply with the guidelines for services of paramedical personnel which are incident to a physician's services.

A physician directed clinic is one where a) a physician, or a number of physicians, is present to perform medical rather than administrative services at all times the clinic is open; b) each patient is under the care of a clinic physician; and c) the non-physician services are under medical supervision.

In order for services of paramedical personnal to be covered under the "incident-to" provision of the Social Security Act, certain conditions must be met. The services must be a) incidental to some professional services of a physician; b) of a kind which is commonly furnished in physicians' offices; c) either rendered without charge or included in the physician's bill; d) performed under the direct supervision of the physician; and e) provided by auxiliary personnel who are employees of the physician. Where paramedical personnel and physicians are employees of the same entity, "incident-to" requirements may be considered met where the supervision is provided by a clinic physician.

"Direct supervision" requires that the physician must at least be on the office premises or place where services are performed and immediately available throughout the rendition of services. In this context, the term "office premises" cannot be construed to extend throughout a building or an institution such as a hospital. The office must be confined to a separately identified area of an institution or building in a realistic amount of space. A physician would not be considered on his office premises if he were simply somewhere in a building or available by telephone. Under such conditions, the direct supervision requirement would not be met.

Medicare may reimburse for services such as day care, occupational therapy, dance therapy, etc., when rendered by non-physicians in a physician directed clinic if such services meet the "incident-to" requirements. This means that individuals receiving such services must be under the care of a physician who performs or has performed a covered physician service to which the service of the paramedical personnel is incident. A physician must also provide supervision and direction of the therapists. A factor to be considered in connection with the physician supervision requirement is the collaborative development by the physician and the therapists of a plan of treatment. The physician does not necessarily have to

have outlined in detail the exact services for the patient, but he is expected to advise the therapists of the goals he wishes to achieve. As a professional person, the therapist develops the details of the plan and obtains the physician's approval. However, unless the paramedical service is related to a covered physician's services as an integral part of a medically necessary diagnostic procedure or treatment or course of treatment, it is not reimbursable.

In addition to satisfying the coverage requirements of "incident-to", the services must be reasonable and necessary for the treatment of the illness. Some facilities incorrectly regard any patient activity as a form of therapy. An activity which merely serves to keep the patient busy should be regarded as diversional rather than therapeutic. Activities such as occupational therapy, dance therapy, social therapy, and day care must be part of a medically necessary planned course of treatment integrally related to a covered physician's services rather than a diversion, or method of keeping the patient occupied, in order to qualify for reimbursement.

Regardless of the actual expenses for physicians' services incurred in connection with the diagnosis and treatment of mental, psychoneurotic or personality disorders of persons who are not inpatients of hospitals,

the amount of such expenses that can be counted in a calendar year is limited to the lesser of $312.50 or 62.5 percent of the actual expenses. Since the $312.50 represents 62.5 percent of $500.00, any amount of non-inpatient psychiatric service expenses in excess of $500.00 would not be considered in computing incurred expenses subject to reimbursement. Since the Medicare Program's share of covered expenses (after the $60.00 deductible) is 80% of the charges, the maximum possible payment for services would be 80% of $312.50, or $250.00.

d. Legislative/Regulatory Restrictions and Conflicting Policies

Nothing significant.

e. Impact on Programs

Minimal. The impact of Medicare on alcohol and drug treatment programs is somewhat indirect, because the main population at risk for these conditions is under age 65. To the extent that abuse of prescribed drugs by the elderly is or becomes a problem, the impact may increase. Medicare is primarily oriented toward hospital or hospital related programs.

3. Vocational Rehabilitation

Vocational Rehabilitation (VR) is a national program that provides services and materials for the rehabilitation of those whose physical or mental disabilities inhibit their employment but who, as a result of VR services, can reasonably be expected to become gainfully employed.

VR funds are distributed through the Rehabilitation Services Administration of HEW to each state vocational rehabilitation agency on a formula grant basis. The state agency, in turn, reimburses those individuals and projects it judges most in need of VR services. Although the majority of program funds (75%) are federal, states have considerable autonomy in determining how they will be used.

Many state VR agencies offer services to drug addicts and alcoholics, although services often are not specifically directed to alcohol and drug abusers. The specific nature of services provided and the requirements of client eligibility vary widely from state to state. Additionally, service availability often varies within a given state on the basis of relative need. For example, services to addicts are more likely to be offered in a metropolitan area than in a rural one. In general, experience indicates that alcoholics and drug addicts are most likely to be included in VR services in the South, Southwest, and West, and least likely to be included in the North and Northwest.

A. Client Eligibility

The 1973 Vocational Rehabilitation Act directed that state VR agencies emphasize services directed at the "severely disabled" and listed several specific conditions in this category. Additionally, criteria were established by which an individual not falling into one of the defined

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categories could be classified as being severely disabled. While substance abuse is not included in the list of severely disabling conditions, it may meet the criteria.

Client eligibility is a problem in many areas in providing vocational rehabilitation services to the addict and alcoholic. Some state agencies have criteria that exclude those under 17 years of age. In other areas, the client must have a specific level of substance abuse before he/she can qualify for VR. In some states VR won't accept alcohol or drug abusers unless they have successfully completed treatment programs. Looser eligibility criteria might provide greater flexibility so that VR can address the unique needs of substance abusers. The definition of disability, which was supposed to be corrected by the 1973 amendments, continues to be a problem.

B. Provider Status

There are no special requirements for provider status under VR. Generally, a state rehabilitation agency works in conjunction with a drug abuse treatment program to provide services to the program's clients. VR may offer employment counseling, skill training, and placement services to an individual who has been treated, or is currently being treated, by a drug program. In some cases, the state agency will place a VR counselor in the program on a full-time or part-time basis. Less frequently, VR will refer addicts to a drug treatment program for services and reimburse the program for such services. State VR agencies have shown some reluctance to expend their limited funds for services provided by another federally supported operation. This is especially true when such services are also made available to individuals without cost.

C. Services Covered

Covered services include any item or service considered necessary to render a handicapped individual employable. These may include, but are not limited to, evaluation of rehabilitation potential; counseling, guidance, referral and placement services; vocational and other training services; physical and mental restoration services, including corrective surgery or therapeutic treatment for physical or mental conditions, hospitalization, provision of prosthetic devices and visual services, diagnosis and treatment for mental and emotional disorders; maintenance during rehabilitation; and other services or devices related to an individual's employability such as sensory aids, occupational training, licenses, tools and equipment.

Despite the flexibility of this definition VR agencies often do not provide the necessary range of support services to alcoholics and drug abusers. An example of this is the agency that gets the client a job, but fails to deal with a personal or home situation which impacts on the client's ability to cope with job responsibilities.

D. Legislative/Regulatory Restrictions

There are many legislative, regulatory restrictions and conflicting policies in vocational rehabilitation. The major problems in this area are the multiple standards, certifications and licensing situations that every program has to comply with before services can be rendered to the clients. These standards are often conflicting, and become obstacles to rather than protectors of client services.

E. Impact on Programs

If VR is not a direct program service, it may create problems, although it both offers third party reimbursements, and adds to the program's spectrum of services. This impact is both negative and positive. Many programs have abandoned VR programs rather than deal with the problem areas. The greatest problem is "criteriaizing" programs to death. The greatest positive thing about VR is that it gives the client hope.

In traditionally restrictive areas or areas where VR monies are fully committed, it is hard to get alcohol and drug services included in VR. Alcohol and drug services may be last in, first out, which causes problems for both programs and clients.

F. Recommendations

1. More Federal Vocational Rehabilitation service funds should flow directly to alcohol and drug programs.
2. Standardize standards, regulations, and criteria.
3. Make standards more client oriented.
4. Develop rehabilitation programs that meet unique needs of alcohol and drug users.
5. Include alcohol and drug abusers within group specifically eligible for VR services.

4. Title XX

Title XX of the Social Security Act was part of the Social Security Amendments of 1974 and became effective on October 1, 1975. Title XX supercedes those portions of Title IV A and VI of the Social Security Act which provided social services to individuals receiving assistance under those provisions of the Act. Under Title XX the Federal government has allocated $2.5 billion annually to be apportioned among the states on a formula basis based on population. The Federal share is 75% for eligible services (90% for family planning) under Title XX.

Each participating state must comply with certain mandated procedures in developing a state plan for the provision and distribution of Title XX services. The plan must include specific indications of the type of services to be provided to individuals and groups in each categorical assistance category and in each geographic region of the state. Although no specific services are required, it is necessary that 50% of the Federal funding a state receives under Title XX be used to provide services to those receiving or eligible for Medicaid, AFDC, SSI, or state financial assistance.

a. Client Eligibility

Eligibility for reimbursement for services under Title XX is based on the income of the service recipient. A

state may receive reimbursement for one or more services to anyone who receives cash payments under AFDC or SSI or who has an income not in excess of 115% of the median income of a family of four in the state. To receive reimbursement fees for services must be charged to those having an income above 80% of the state median. Protective services and information services are available without determination of eligibility to those of all income levels.

The process of eligibility determination is at conflict in spirit with the confidentiality regulations regarding chemically dependent individuals in rehabilitation programs. Sources and amounts of family income must be verified, resulting in contacts with employers, public assistance sources, etc. It is extremely difficult to maintain confidentiality while at the same time collecting financial information regarding the client and/or the client's family. If Title XX is the sole source of program funding, income limitations may discourage involving non-indigent clients in treatment programs.

Because of the stringent verification requirements some areas have decided against funding alcohol and drug programs under Title XX and have instead used the funds in other areas where verification is less of a problem.

b. Provider Status

Programs must be specifically accorded provider status. Services may be provided directly, by compact, or under purchase of service agreements. In some states all alcohol or drug treatment programs may be involved in master contracts with the State Social Services program.

c. Services Covered

To be eligible for Title XX funding services are to be directed to one or more of the following goals:

1) To achieve or maintain economic self-support to prevent, reduce, or eliminate dependency;

2) To achieve or maintain self-sufficiency, including reduction or prevention of dependency;

3) To prevent or remedy neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating, or re-uniting families.

4) To prevent or reduce inappropriate institutional care by providing for community-based care or other forms of less intensive care; or

5) To secure referral or admission for institutional care when other forms of care are not appropriate, or provide services to individuals in institutions.

Title XX service categories do not prohibit the inclusion of modalities normally included within the continuum of care. Within the states there may be disputes about what aspects of alcohol and drug treatment are covered. However, priorities are up to the state and virtually any service may be covered if the state is willing.

d. Legislative/Regulatory Restrictions and Conflicting Policies

In some states Title XX is being used to replace mandatory state funding despite maintenance of effort provisions. As noted earlier, there is potential conflict between confidentiality and income verification. In addition, several other restrictions and/or requirements pose potential problems:

1) Need to redetermine eligibility versus halfway houses--- Title XX requires that eligibility be redetermined every 6 months or when the client has a change in his/her living situation which may make the client ineligible for Title XX reimbursement. Obviously, halfway house clients are encouraged to seek employment; however, upon securing employment which compensates above the established cut-offs, the halfway house must either terminate services or seek reimbursement from alternative sources (or ignore the increased income and in effect enter into fraud.)

2) Financial limitations are placed on costs for medical and board and room services within the total budget. No more than 25% or 40% of a program's total budget may be spent for medication and board and room expenses, respectively. Although these limitations have been waived for a four-month trial period, pursuant to amendments introduced by Senator Hathaway, there has been no indication from HEW/SRS to state Title XX agencies of this trial modification.

3) Limitations on Board and Room: As in Title IVA, Federal reimbursement for board and room costs is available, up to 40% of total charges, for only a six-month period; thus, extended rehabilitation services must seek alternative sources of funding for board and room costs after a client has completed six-month participation.

4) There may be conflicting interpretations between the Title XX Agency and the Medicaid Agency concerning what services are reimbursable under each program, and a program may have to choose one or the other as its primary funding source.

5) There is a cloud over the full and imaginative use of Title XX funds because of the problem of later audit exceptions (the refusal to reimburse the state after services have been delivered according to the state plan). This is often related to the need for individual

eligibility determinations and tends to force states into conservative postures regarding what they seek to fund under Title XX. It also discourages the use of these funds for services. Some states, for example, have had reimbursements for alcoholism services denied.

6) There are great differences in regional interpretations.

7) Title XX funds are available for rental payments for program facilities, but not for mortgage payments. Thus, programs seeking ownership of their facilities cannot receive aid for this purpose, although they could receive rental monies for the same facilities.

e. Impact on Programs

It is not practical to use these funds for some services because of overhead costs. It should be noted that when programs are required to conduct the verification process more staff time may be spent in clerical areas, necessitating reallocation of resources to administrative costs/overhead rather than treatment.

f. Recommendations

Based on our concerns, some of which may be met by the Hathaway amendments depending on the Regulations developed, the following recommendations are made:

1) Clarification of the conflict between confidentiality and income verification. Obviously, one concept must be considered to take precedence over the other.

2) Re-wording of redetermination requirements to permit halfway house clients to secure employment without fear of economic penalty.

3) Limitations on board and room have been amended by the Hathaway amendments. However, there has been bureaucratic inactivity in advising states and local units of government about the trial modifications. This foot-dragging will likely enable legislative opponents of the modifications to successfully defeat continued application of amendments.

4) Removing limitations on length of board and room reimbursement thereby insuring federal reimbursement for board and room costs for the duration of extended treatment programs.

g. Issues that Need Further Explanation

Two additional areas of concern have been raised; however, it is unclear as to whether these are prompted by the regulations, HEW's implementation of the regulations, or state welfare departments' implementation of the regulations.

1) In Minnesota, detoxification services are available for financial reimbursement only if clients meet eligibility criteria. However, Title XX allows for adult protective services to be extended without regard to income. The Regional Office says juvenile protective

services can be residential, but protective services for adults cannot. This appears to be a very conservative approach to defining services which are included under the adult protection category.

2) Information and referral services are defined as a "brief assessment" which is not to include diagnosis and evaluation. In addition, I & R services must be provided only on a one-to-one basis. There has been little substantive assistance provided to local governmental units in defining what is included under "brief assessment." In addition, prohibitions against group I & R services reduces the opportunity to fund innovative I & R activity.

Supplemental Security Income

A. Client Eligibility

Supplemental Security Income (SSI) is an income supplement program which was established in 1973 as a replacement for federally assisted state public assistance programs. The program replaces most previous Federal-State programs of financial assistance to aged, blind, disabled. While alcoholism and drug addiction alone do not render an individual as disabled for purposes of the Act, they may be the basis for a finding of disability if they render an individual unable to engage in any substantial gainful activity and the condition is expected to result in death or to last for more than 12 continuous months.

Individuals receiving SSI by virtue of disability due to alcohol or drug use, or if alcohol or drug addiction is a contributing factor to a finding of disability, must participate in appropriate treatment if a program is available. There are no funds set aside to pay for the required treatment. For individuals whose disability is due to alcoholism or drug addiction SSI payments are made to a "representative payee" (which could be a treatment program).

Although disability standards under SSI appear to be stricter than under former programs - especially

for alcoholics and addicts - some areas report that the standard is actually less strict.

B. Services Covered

Not relevant since this is a cash assistance program to the categorically needy.

C. Legislative Restrictions and Conflicting Policies

In some states SSI agencies will not release income documentation information. Where this is so it severely handicaps compliance with Title XX regulations.

Although voluntary assignment of SSI benefits to a representative payee is relatively easy, involuntary assignment is difficult. This is a problem where, as is often the case, an addiction is present but it is not the primary basis for disability so there is no treatment requirement. There is a serious conflict here between care needs (which require guardianship) and civil liberties (which require freedom to continue the addiction).

D. Impact on Programs

It is estimated that 20% to 30% of the clients using local alcohol and drug services are recipients of SSI. For many, this income is a blessing. However, SSI payments, especially where addiction is a secondary diagnosis so there is no representative payee requirement, may simply be used to support the addiction. Except for individuals whose primary disability is alcohol or

drug abuse it is much more difficult to obtain some form of guardianship or protective payee status for SSI clients than it was for clients in the previous public assistance programs.

E. Recommendations

1. There should be tighter monitoring of the program;
2. There should be more frequent reassessment of client eligibility;
3. There should be better provision for guardianship status; and
4. There should be broader cooperation with other agencies for such purposes as complying with Title XX regulations.

6. CHAMPUS

a. Client Eligibility

The CHAMPUS program applies to all of the seven United States Uniformed Services: Army, Navy, Air Force, Marine Corps, Coast Guard, and the Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Administration (formerly Coast and Geodetic Survey and ESSA). Civilian health care benefits under CHAMPUS are available to:

- Spouses and children of members on active duty, and the surviving spouses and children of deceased active duty members.
- Retired members and former members who are entitled to retired, retainer, or equivalent pay; their spouses and children and the surviving spouses and children of such members who are deceased.
- Children include any unmarried legitimate child, an adopted child or stepchild in one of the following categories;
  a. Under 21 years of age.
  b. 20 or over, but incapable of self-support because of a mental or physical incapacity that existed before the 21st birthday, and is (or was at the time of the member's death) dependent on the member for more than one-half of his support.

c. Under 23 and enrolled in a full-time course in an accredited institution of higher learning and dependent on the sponsor for more than one-half of his support.

(An unmarried child or stepchild who was illegitimate at the time of birth and is dependent on the member may be covered under certain conditions.)

b. Provider Status

Medical services may be provided by a civilian physician or by other medically related specialists as ordered by a physician (nurse, physical therapist, social worker, etc.). Authorized services of a clinical psychologist may be provided without a physician's order. Services are also authorized from Christian Science approved practitioners and in a certified Christian Science sanatorium. Inpatient and outpatient care must be in facilities approved by Champus.

JCAH accreditation is required for all psychiatric hospitals. Residential facilities such as half-way houses can be considered "hospitals" subject to approval of CHAMPUS. A physician must be actively involved in providing treatment and prescribing treatment conducted by those other than physicians.

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c. Services Covered

Generally, CHAMPUS will share the cost of any necessary medical or surgical procedure or any type of necessary medical care which is accepted as being part of good medical practice.

Treatment may be either on an inpatient or outpatient basis. Treatment in inpatient facilities is generally authorized for an unlimited number of days. When a patient requires continuous hospitalization in excess of 90 days for treatment of a chronic condition or a nervous, mental or emotional disorder, the proposed course of treatment must be specifically approved.

Treatment for alcoholism and drug abuse is subsumed under the rubric of care for nervous and mental conditions. Authorized care for alcohol and drug abuse must be "medical care" or an integral part of a medical treatment plan. Services provided by half-way houses or other residential treatment facilities specializing in the treatment of alcohol or drug abuse may be authorized as "hospitalization" provided a physician is actively involved in the supervision of treatment and facility otherwise meets CHAMPUS requirements for accreditation. (Generally JCAH, although

CHAMPUS is not presently proposing to accept facilities accredited pursuant to the JCAH Standards for Drug Programs, because they are not sufficiently medically oriented.)

Treatment or counseling provided by a wide range of individuals other than psychiatrists or licensed psychologists must be specifically requested by a physician and such treatment or counseling must be "recertified" by the physician every 30 days. Treatment for psychiatric conditions (excluding alcohol and drug abuse) is limited to 120 days of inpatient care or 60 outpatient visits per calendar year.

d. Legislative Restrictions

Because of the rapidly increased costs of the CHAMPUS program, particularly in the area of nervous and mental care, legislation has been proposed to exclude all services not considered "medical" and all providers of services, individuals or institutions, not considered part of the medical team. Thus it is probable that services provided by social workers, educators, family and child counselors and "others not considered a part

of the medical team" will be curtailed. This may seriously decrease the potential for reimbursement for alcohol and drug services to any program which does not strictly conform to the medical model.

e. Impact on Programs

In the Orange County, California, facilities which have been approved for CHAMPUS coverage, there is no problem in client coverage for alcoholic diagnoses. This includes all mental health services related to alcohol where services are provided directly or requested by a physician. CHAMPUS in Orange County will not cover where a drug dependency diagnostic code is used.

f. Recommendations

1. It should be clarified, on a national basis, that services delivered under a diagnostic code of drug dependence will be covered.

2. CHAMPUS should endeavor to regularly determine its costs for alcohol and drug treatment services on a total, per facility, and per patient basis.

3. Alcohol and drug abuse services should not be too strictly forced into the medical model to collect CHAMPUS payments.

Note: CHAMPUS is only one of variety of Federal programs for the purchase of services for individual clients. Other relevant programs include those operated for active duty

military personnel by the Department of Defense, Veterans Administration programs, and Bureau of Prison programs. These programs may produce revenue for local programs in a variety of situations, including some program components, such as half-way houses, which are often excluded by other funding sources.

C. Private Funds

1. Health Insurance

a. Coverage for Alcoholism and Drug Abuse Treatment

Traditionally private health insurers have limited, and in many cases totally excluded, coverage for treatment of alcoholism and drug abuse. In recent years, however, a number of companies have taken steps to significantly expand the availability of coverage for such treatment. Presently most insurance companies cover alcoholism and drug abuse on the same basis as they cover other conditions. Thus, treatment of alcoholism or drug abuse, up to the policy limits for any condition, would be covered if the treatment occurs in an approved facility (usually a general hospital) and is given by an approved provider (usually a doctor or related health care personnel operating under the supervision of a doctor).

A few insurers have moved beyond this to cover alcoholism and drug abuse treatment services in settings other than a general hospital, and to reimburse for the services of non-physician providers. Such expanded coverage is only beginning and insurers voice a number of concerns about general movement in this direction. Such concerns include a lack of accepted standards and modalities for the treatment of alcoholism and drug abuse, a lack of state or local licensure programs for such facilities, and a lack of accepted national standards upon which insurers can base their decision to pay or not pay for care by certain providers in certain facilities. Thus, although coverage for treatment for alcoholics and drug abusers is increasingly available in private insurance policies, such coverage rarely covers outpatient programs not associated with a hospital, or

residential or day treatment programs which are not patterned on the medical model.

There is an increasing awareness on the part of insurers and treatment providers that the kind of insurance coverage presently generally available for such conditions encourages treatment providers to opt for the type of care which is most expensive---inpatient care in a licensed general hospital---when other kinds of care are available which are equally or more effective and significantly less costly.

Thus a serious problem with private insurance reimbursements for alcohol and drug treatment services is the fact that such payments are available only to programs based on the medical model.

HMOs have found the use of non-hospital, non-medical services---particularly in the alcoholism area---has a significant cost reduction effect. Early intervention in both alcohol and drug problem areas makes overall treatment less expensive.

b. Mandatory Coverage

A number of states, in the past two or three years, have enacted legislation prohibiting exclusions of coverage for treatment of alcoholism and drug abuse in insurance policies sold in those states. Twelve states have enacted such legislation concerning alcohol treatment and five for drug abuse treatment. The specific provisions of such laws vary widely with some simply prohibiting the exclusion of insurance benefits for such treatment while others mandate the inclusion of specific insurance benefits for alcohol and drug abuse treatment services. Where benefits are mandated they normally are simply required to be equal to benefits available for

treatment of other conditions. A few states have also required insurance companies to offer a benefit for alcoholism and drug abuse services with the option being in the policy holder to decide whether such services are desired. Since most mandatory coverage statutes simply place alcoholism or drug abuse services in the same position as treatment services offered for other illnesses, the existence of a mandatory coverage statute normally means simply that inpatient treatment costs, or the costs of medical services for alcohol or drug abuse treatment will be covered.

However, mandatory coverage legislation was responsible for pushing HMO's to include payment for lower-priced care alternatives in the alcoholism area.

c. Program Experiences

Minnesota has had a mandatory coverage statute in effect for approximately one year. Under the Minnesota statute services provided in either hospital based or free standing licensed residential treatment programs are covered. Currently private insurance payments are the single major source of income for hospital based chemical dependency treatment programs, and the amount of private insurance reimbursement being obtained by free standing treatment programs is increasingly significant. The Minnesota experience has thus far been satisfactory and insurance companies generally are complying with the legislative mandate.

There are, however, two problems. The statute only applies to contracts written in Minnesota, which means that persons insured under a group contract written in another state may not have coverage for alcoholism and drug treatment services, despite the fact that such individuals live

and work in Minnesota. Also, the legislation does not apply to self-insurance programs so that any companies which write their own insurance would not be covered.

Kansas and Missouri have mandatory coverage statutes applicable only to alcoholism. Although there is little experience to date under these statutes, the local Blue Cross/Blue Shield plans objected to their enactment and express concern that claims could become excessive.

In some states where insurance companies have voluntarily extended benefits to cover alcohol treatment, there has been reluctance to use the services because employees fear that their employers will learn of their alcohol or drug problems if they claim insurance benefits. In California, where alcohol treatment benefits were incorporated into the insurance benefit package of all State employees, utilization of the benefit has been far below the anticipated level as reflected in the appropriation.

2. HMOs (Health Maintenance Organizations)

As is true in the indemnity insurance field, there are a number of approaches to funding coverage for alcohol and drug abuse in the HMO/Prepaid Group Practice sector of the delivery system. Although there is wide variation in structure, size and benefits among such plans, for purposes of this document the generic term HMO will be applied to all prepaid group practices.

The HMO Act of 1973 dictates that certain services relating to alcohol and drug problems must be included as part of the basic benefit package for any federally-qualified HMO. These include provisions for emergency, referral and follow-up care. Unfortunately, there is no clear definition of what these services encompass. Nonetheless, HMOs which seek federal qualification and/or funding for feasibility, development or initial operation must factor these services into their capitation rate. No reliable data appear to be available on the actual cost of such services, although, as previously indicated, some HMOs have demonstrated that it is less expensive to provide such services through early intervention and outpatient programs than through inpatient care.

The House has passed an amendment to the HMO Act which moves alcohol and drug abuse services from the basic benefit package to the supplemental, or optional, category. The Senate is holding hearings in December and January on the HMO Amendments. Current indications are that there is strong support in the Senate Committee for retaining alcohol and drug abuse as basic benefits for federally-qualified HMOs.

Operational HMOs which offer alcohol and/or drug abuse coverage approach the coverage and funding in various ways, and benefits range from none to very comprehensive. Coverage is sometimes included under the Mental Health benefit, which also varies considerably. Funding is approached from several perspectives. In some plans, the benefit is an add-on at extra cost; in others, it is contained in the basic package. Some health plans offer coverage to only a portion of their membership (generally employer groups which have requested it), others make it available generally. There is a co-payment feature in many HMOs, where the user is required to pay a certain percentage of the cost on a predetermined scale for specific types of services.

Virtually all HMOs are providing emergency services for alcohol and drug misuse. Emergencies may be handled directly as cases of acute toxicity or, less directly, as a secondary presenting symptom or trauma resulting from alcohol and/or drug use. Apart from emergency treatment, however, alcohol and drug abuse are not routinely diagnosed and treated under specific diagnoses such as alcoholism, addiction or non-medical use of drugs. As in the health care system generally, there is a lack of proper training in recognizing and treating patterns of abuse as well as attitudinal and cultural barriers to dealing with patients in this area.

A few HMOs do have an in-house capacity for treating alcohol or drug abuse, or a contractual arrangement for referral and payment to other programs. More plans, but still not many, make referrals to other community resources, ranging from AA to inpatient hospital programs, with the expense generally borne by the patient.

The Group Health Association of America is conducting a demonstration-research project funded by NIAAA, to examine utilization and health care costs for persons identified as having a primary alcohol-related problem. Figures will be calculated both prior to and subsequent to exposure to alcohol treatment The results may show a change in the pattern of utilization of the health plan which will actually reduce costs over a period of time by making primary alcoholism diagnoses and providing appropriate treatment rather than treating secondary presenting symptoms and emergency situations. The response within the limited number of health plans involved has been enthusiastic.

There appears to be less acceptance by HMO staff regarding drug abuse clients. This may be the result of the national focus, which has implanted a strong image of the drug abuser as a street person using opiates. However, at least one plan is surveying drug utilization and prescribing patterns of the potential legal drugs of abuse. Additionally, as part of the alcoholism project, GHAA is trying to determine if there is a concomitant misuse of certain drugs, including both legal and illegal substances, on the part of patients identified as having an alcohol problem, or by members of their families.

The HMOs have a potential for an effective approach to identification and treatment, both as to cost and effectiveness, which is unique. The relatively closed system, where every provider contact is available on one record, could be utilized effectively to assess patterns of alcohol and drug abuse and alternative treatment mechanisms. Since preventive health care is the basis of the HMO philosophy, HMOs should be encouraged to increase their awareness of the need for and efficacy of providing

appropriate treatment services for those of their members who suffer from or develop problems of misuse of alcohol and drugs.

3. Others

a) Foundations: With rare, but notable exceptions, national foundations do not provide regular or ongoing funding support to addiction service programs. As a rule, foundation support for local funding of alcohol/drug programs cannot be viewed as a long term source of financial assistance. There is a wide local variation in the availability of foundation support for alcohol and drug services. However, while local foundations may be a very good contact for partial initiation funding or one time capitalization expense, the funding behavior of most family foundations does not extend beyond a one or two year commitment. Highly visible community oriented projects with broad based support have considerable appeal to foundations with geographical ties but, as noted, they are normally not a viable source of ongoing funding of alcohol/drug services.

b) Local "Scrounging": Scrounging is the term generally applied to efforts of community-based programs to sustain or enrich their ability to deliver services. To some extent scrounging may describe activities aimed at locating and soliciting public or foundation funds available to support community-based programs or a portion of their components. As such resources are covered elsewhere in this report, however, this statement will address itself

to more informal, creative efforts.

Most locally-based drug and alcohol programs utilize a variety of forms of fund raising. Some have annual or even more frequent formal banquets which serve the dual purpose of acquainting the community served with their activities and raising needed revenues. There are also a wide variety of raffles, fiestas, bazaars, and sales which bring in a trickle of funds to the agencies organizing them.

Community centers also utilize a wide variety of services and supplies obtained from the community. Some centers have few if any paid staff and rely almost totally on volunteers. Centers also operate out of donated facilities utilizing equipment and supplies which have been donated by clients and/or community individuals and organizations.

Scrounging, at best, tends to be a very uncertain source of program support. On some occasions a program may be highly successful and be able to provide a wide range of services to the community it serves. When economic difficulties hit the community, however, resources formerly available to scrounging programs tend to disappear and co[illegible]ies are deprived of services at the very times they most [illegible]ed them.

As a funding mechanism, scrounging very simply means that staff, and in some instances clients, unabashedly solicit the community in which their program is located for money, goods, and services. Most often, however, the contributions are in kind donations. To enhance the appeal and insure a community contribution, the scrounging project is often organized around a special need. The two clearest functions satisfied by scrounging in the context of all other funding mechanisms are an increase in community awareness of the particular program, and the obtaining by a program of goods and services which are not available through other more routine channels.

Alcohol and drug programs, especially community-based programs, tend to be very good at scrounging. They have had to develop this ability in order to survive.

Interestingly, as programs are able to scrounge more funds they are often also able to get more public funds. It is important for formally funded programs to maintain their local scrounging ability to maintain community contacts and to provide a source of funds for new and innovative programs. Although the ability of a program to obtain funds by scrounging suggests that the program is responding to public needs, it is possible that scrounging support itself may become institutionalized

so that funds flow to a program which is non-responsive to the public.

It is often difficult for programs which have been highly dependent on scrounging to make a smooth transition to more bureaucratic forms of funding.

Because scrounging is an unstable and unpredictable source of support it is difficult to support basic treatment programs through scrounging. Community-based, non-traditional programs are more likely to have this type of funding.

The ability of a program to scrounge effectively is directly related to the community's awareness of the underlying problem. In some areas the community denies the existence of an alcohol or drug problem---and does not respond to efforts to scrounge support for programs in these areas.

Match requirements in project grants, where applied to community-based programs, encourage continued efforts at scrounging support. Although scrounged funds may support a project prior to the receipt of public funds, scrounging cannot be a substitute for a Federal or State commitment to dealing with alcohol and drug problems.

In some instances clients are required to scrounge as part of the rehabilitative process.

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One form of scrounging, which combines most other kinds and should be given a great deal of additional study, is the service-for-service concept. Centers using this program ask each client to agree to return to the program money, service, or supplies approximately equal in value to services received. As each individual has some unique abilities and/or resources, and as increased self-esteem is usually an important aspect of therapy or treatment, not only does the program gain an increased ability to sustain itself through this mechanism, but clients tend to feel increased self-esteem through their ability to pay their own way. In economic hard times, when even a client eager to repay the center has difficulty supporting himself and finds it almost impossible to fulfill his debt to the drug or alcohol program, perhaps some form of Government loan to the program in the name of the individual would be a useful supplement.

III. NATIONAL HEALTH INSURANCE (NHI)

1. General Concepts of National Health Insurance

National health insurance, as it is generally discussed, would create a mechanism for the payment of specified health care costs for individuals covered under the program. Among the numerous bills which have been introduced in Congress there is a wide variation on a number of basic points including the questions of eligibility (universal vs. limited), benefit structure (comprehensive, semi-comprehensive with phased-in benefits, or catastrophic), financing (out of general tax revenues, special taxes or premiums, employer contributions, employer-employee cost sharing, etc.), administration (private insurance carriers vs. governmental administration), and cost sharing (full payment for all services vs. some program of deductibles and copayments). Obviously the way in which each of these issues is resolved can have a significant impact on the extent to which a national health insurance program is available for and utilized to provide financing for alcohol and drug abuse treatment services. The resolution of these issues will likewise determine the extent to which national health insurapce financing supports a continuation of the trend toward utilization of high cost medical and hospital services or encourages the substitution of lower cost forms of health care, perhaps provided by non-medical personnel in non-hospital facilities.

Although all of these issues are important the two factors which would appear to have the most impact on alcohol and drug abuse treatment programs are the question of eligibility and the question of benefit structure. Either a catastrophic national health insurance program or one

with a limited benefit structure would have far less potential for substance abuse program financing than would a program with a benefit structure which provides coverage for a full range of alcohol and drug abuse services, including services given in a non-hospital setting and services given by non-medical personnel. Likewise, a program with less than universal eligibility, particularly if the eligibility is related to employment, will leave without coverage those categories of individuals whose alcohol and drug problems are most likely to involve them in crime or other antisocial behavior and whose treatment, therefore, is most socially beneficial.

The range of potential benefit structures under the bills which have been introduced thus far varies widely. Of the bills proposed in the 94th Congress, only two provide explicit coverage for alcohol and drug problem services. They differ in approach and coverage.

The broadest coverage is proposed under the Health Security Act of 1975 (H.R. 21), introduced by Representative James C. Corman and Senator Edward M. Kennedy. This bill would provide the following coverage for alcohol and drug abuse treatment:

1. Inpatient Benefits---Unlimited. Treated as any other physical illness. No deductibles or coinsurance.
2. Physicians' Services---Unlimited, as in the case of all other physical illnesses covered by the bill.
3. Outpatient Benefits---A person diagnosed as alcoholic would be able to receive services not only from hospitals, mental health centers and other providers who offer alcoholism and drug services, but could also be treated as an outpatient in a free-standing ambulatory center.

Somewhat more limited is the National Health Care Services Reorganization and Financing Act (H.R. 1), introduced by Representative Al Ullman. This bill provides the following benefits applicable to alcohol and drug treatment services:

1. Inpatient Benefits---90 days of inpatient hospital care received in any benefit period; copayment $5 per day.
2. Physicians' Services---Limited to first ten visits to physicians and services of other qualified health professionals and allied health personnel per coverage year. Copayment $2 for each physician visit.
3. Outpatient Services---Outpatient institutional care programs for physically disabled, mentally ill, alcoholic and drug-abusing persons would include day care or part-time services. A person diagnosed as an alcoholic or drug abuser would be entitled to three days of outpatient care in place of each day of inpatient care allowable during a benefit period.

The other bills rely on conventional or standard forms of hospital and professional care. They tend to ignore the range of services needed outside the medical care setting and thus would be limited in the applicability to alcohol and drug services. The lack of coverage for aftercare services would likely abort any treatment gain initiated in the hospital for alcohol and drug problems.

Unlimited coverage of inpatient benefits and physician services may contribute to higher cost for services. There is some limited data in the California experience to suggest that citizens with alcoholism problems and treatment providers favor hospital care, if there is no clear incentive to avoid it. A great deal of alcohol and drug abuse care can and should be provided in

non-hospital settings. Much also can be done on a non-residential basis. Perhaps there should be limits on institutional care and in addition, incentives like that proposed by Representative Ullman, entitling a person to three days of outpatient care in place of each day of inpatient care.

2. Discussion of Benefit Package

a. Ideal Coverage

National health insurance should be a mechanism to provide needed health care, not just medical services. Alcoholism and drug abuse should not be singled out in NHI legislation, either for special inclusions or special exclusions. However, there is a need to include under national health insurance a full range of services applicable to alcohol and drug abuse treatment, and to the treatment of other conditions.

The ideal coverage package is one which would provide coverage for the full spectrum of medical care and related supportive services for the treatment of alcoholism and drug abuse in addition to comprehensive coverage for other health care problems. Such ideal coverage would include a full range of inpatient and medical services as well as outpatient and residential programs and appropriate care given by non-medical personnel. Although a full range of services should ideally be covered, it is entirely appropriate that reimbursement be contingent upon service providers, both personnel and facilities, conforming to appropriate standards of quality care. Such standards might include state or local licensure, JCAH accreditation, and state or national certification or credentialing of treatment personnel.

It is important that NHI fund sufficient alcohol and drug treatment services to allow patients to receive the continuum of care discussed earlier. What is important is that an individual be carried from his present state of health to a better one. NHI should encourage the use of the range of services necessary to achieve this goal, and should not be structured to interfere with the utilization of the necessary continuum of care.

Ideally, then, NHI should cover all care for the direct treatment of alcoholism or drug abuse whether or not the care is delivered by a program or facility based upon the medical model. Looking at the components of care identified earlier, it is the Task Force view that Crisis Management, Primary Treatment and Rehabilitation, Transitional/Aftercare, and Supportive Services are appropriate for NHI funding.

b. Minimum Coverage

In the event that it is determined that coverage for the full range of alcohol and drug treatment services will not be available under national health insurance, and that NHI will be primarily a medical reimbursement system, it is important that no exclusion be made for the treatment of such conditions. At minimum, the same services for treatment of alcoholism and drug abuse should be covered as are covered for the treatment of any other physical or mental condition.

If NHI will not be available to cover the full range of services necessary to provide treatment to an individual suffering from alcoholism or drug abuse, because many of these services do not conform to the medical model, it must be understood that NHI will have limited applicability to

financing treatment for these conditions. Alternative sources of funding should be specifically identified.

3. Limitations

A number of the necessary services for the treatment of alcoholism and drug abuse fall outside of the spectrum of hospital/medical care which is normally covered by health insurance programs and which is the immediate target of NHI legislation. To the extent that national health insurance continues this focus, it is unlikely that NHI will provide for the full range of necessary services. Enactment of any NHI package, even one which does not fully provide for alcohol and drug abuse treatment services, may lead to a decrease in categorical funding and, thus, may lessen the availability of resources for home care, counseling services, work-related programs, and other forms of service which have proven successful in dealing with individuals with alcohol and drug abuse problems at considerably less cost than care in hospitals or other medical institutions. Prevention programs, which are unlikely to be funded under NHI in any event, would also suffer if categorical funding is decreased because of NHI.

Further, national health insurance, assuming such a program is based upon a traditional health insurance model, will have the characteristics and limitations of other third party payment mechanisms. These include:

- Reimbursement of services rendered. There is no provision for the development of facilities, the training of personnel, the design of outreach programs and so on. The assumption is that providers are ready, willing and able to serve an increasing

number of patients---if only they or a third party would pay their bills.

- Third party health payment schemes usually fail to specify the types of medical services to be made available, such as eye, ear, nose and throat. Instead, they break services into such categories as hospital, physicians', nursing, inpatient and outpatient. Given such categories, it is often impossible to determine the specific treatment being reimbursed since the reporting system fails to cut across services as they relate to illnesses.
- Third party health payment is primarily hospital and physician oriented.
- Third party health payment is available only through "qualified providers," however they may be defined. This relates to the whole issue of who determines provider eligibility and who sets the standards.
- Third party payment is available only through eligible programs. Again, program eligibility for reimbursement and the mechanism by which standards are set are critical issues.
- Third party health payment is available only to eligible clients and often under rigidly defined circumstances. The question of who is covered under a particular health plan and the exclusions under which that coverage is extended becomes a vital consideration.

It is clear that if NHI is to be a viable source of funding for a broad range of alcohol and drug services it will have to be defined as a program for the provision of health care rather than a program for the provision of medical services. To the extent that this occurs and qualified,

non-traditional alcohol and drug service programs are reimbursable under MHI, MHI will have relevance as a funding mechanism for alcohol and drug treatment services.

IV. Differences in Alcoholism and Drug Abuse which may have an impact on Funding

1. Alcoholism tends to be more broadly covered by private insurance than is drug abuse.

2. Alcoholics tend to be more affluent than other drug abusers and are more likely to have private health insurance than are opiate abusers.

3. A larger portion of the drug abusing population is seriously involved with the criminal justice system, solely by reason of their drug use, than is the case with alcohol abusers. This factor has an impact both on public perceptions and reactions to drug abuse and the drug abuser and on the point and mode of client entry into the drug treatment delivery system.

4. Alcoholism is more widely known and acceptable than is drug abuse, and carries a significantly lesser degree of social stigma. Moreover, drug use in and of itself carries, at many levels of society, a stigma which is not carried by alcohol use. These factors impact on the general sympathy for the two conditions and, therefore, on the availability of funds.

5. Historically, the alcoholic tends to be older than the drug abuser.

V. ADDITIONAL RECOMMENDATIONS

(These recommendations are in addition to the recommendations specifically contained under the discussions of specific funding sources.)

1. Because of the impact of service definitions on the availability of funds through reimbursement programs, the JCAH should give leadership in the development of consistent service definitions for the alcohol and drug abuse field.

2. Alcohol and drug abuse treatment programs should be encouraged to structure themselves on a management by objective basis so that they define for themselves specific goals and objectives, rather than being forced into present structures because they have been traditionally utilized by funding sources.

3. A funding source matrix, along the lines of that contained in this report, should be utilized by the Federal Government as a continued feedback mechanism on funding sources for local and state programs.

4. More attention should be focused on assuring funding for the full continuum of services rather than on arbitrarily defining acceptable services in terms of funding resource categories.

5. Total Federal funding available for alcohol and drug services should increase, whether through increased authorization and appropriation for formula grants, or increased project grant funding.

VI. ISSUES THAT NEED FURTHER EXPLORATION

The Task Force identified a number of key issues relating to the funding of alcohol and drug services, which it could not explore in this Report because of constraints of time and resources. These issues are listed here with the hope that NIDA, NIAAA and/or private organizations will initiate or support studies of them.

1. The varying impact of formula and project grants.
2. Issues relating to confidentiality problems in dealing with various funding sources.
3. The relationship of third party payment funding to the total funding needs for alcohol and drug abuse services as defined by the continuum of care concept outlined in this paper.
4. The impact of 93-641 (the National Health Planning and Resource Development Act) on alcohol and drug abuse programs.
5. The impact of various funding mechanisms on special populations.
6. The impact on the delivery system of mandatory and voluntary private health insurance coverages.
7. The development of a mechanism to routinely collect, on a system-wide basis, funding information such as that contained in the matrix.
8. The impact of NIDA slot contracts on programs.
9. The "cost of accountability". By this the Committee means the impact of increasing overhead requirements on programs ability to deliver services.
10. A comparison of the model benefit packages for alcoholism and drug abuse.

11. An assessment of the varying constituencies of alcoholism and drug abuse and how these impact on developing needed public support for such programs.

12. Definitions of service elements as they relate to various funding sources.

Mr. ROGERS. Thank you very much, Dr. Price, for a very helpful statement, and we appreciate your being here and giving it to us.

Mr. Hefner?

Mr. HEFNER. Thank you, Mr. Chairman.

I have no questions at this time. I would like to reserve the right for a question later.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. You are an M.D.?

Mr PRICE. No, sir; I am a Ph. D.

Mr. CARTER. Psychology?

Mr. PRICE. As a matter of fact, sir, it is in theology. I am an ordained clergyman in the United Methodist Church.

Mr. CARTER. What is your present position, please, sir?

Mr. PRICE. I am the executive director of the Council of State and Territorial Alcoholism Authorities.

Mr. CARTER. Executive director?

Mr. PRICE. The Council of State and Territorial Alcoholism Authorities.

Mr. CARTER. Yes, sir.

What are your duties?

Mr. PRICE. We have a grant from NIAAA. We are the National Association of the State Alcoholism Program Administrators in the 56 States. We have a grant from NIAAA to coordinate State programs, to develop information about what is going on in the States, and to work with States in strengthening their State programs. We communicate State needs to NIAAA. We communicate some of NIAAA directives to the States and——

Mr. CARTER. And support every increase in appropriation and authorization.

Mr. PRICE. I am sorry——

Mr. CARTER. And support every increase in authorization and appropriation; is that correct?

Mr. PRICE. Not as a matter of ideology. We also have a large amount of money to evaluate treatment programs at the State level.

Mr. CARTER. Are you an evaluator?

Mr. PRICE. I have an evaluator on my staff.

Mr. CARTER. You have an evaluator on your staff. What is his training, please, sir?

Mr. PRICE. He has a Ph. D. in physics.

Mr. CARTER. Physics?

Mr. PRICE. And he came to us from Rand Corp.

Mr. CARTER. He has a Ph. D in physics and he is evaluating your program on alcoholism?

Mr PRICE. In terms of the technology of systems development, in the collection of data, and the use of computers. This is where his expertise is. The development of criteria regarding treatment and this sort of thing——

Mr. CARTER. Describe to me how an alcoholic gets help from one of your divisions, how you contact him, and how he is assisted.

Mr. PRICE. Our association does not provide direct treatment services.

Mr. CARTER. You are just a coordinator and collator of facts, and so on; is that right, and provide——

Mr. PRICE. And provide technical assistance.

Mr. CARTER. What is your particular expertise in this field besides being a doctor of theology?

Mr. PRICE. For 10 years, I was with the United Methodist Church as director of their department of alcohol problems. I was program planner working with clergy and with laypeople——

Mr. CARTER. Let me commend you on that. I think that is fine.

What percentage, actually, of the funds which are appropriated for alcoholism actually goes to treatment, and what percentage goes to administration?

Mr. PRICE. The figures we have, sir, which I quoted, were put together by NIAAA. On the formula grant funds only 4.3 percent is earmarked for administration.

Mr. CARTER. I know it is only that but I believe more than that is spent on administration, a lot more.

Mr. PRICE. It is hard to tell.

Mr. CARTER. No; it is not too hard, neither.

Mr. PRICE. The figures I was quoting are based on State plan budgets where at least 50 percent——

Mr. CARTER. Why do some of our mental health associations say that the cost of administration should be cut by 50 percent?

Mr. PRICE. I am not sure at all.

Mr. CARTER. Yes, sir.

Could you tell me about the staffing of mental health, of centers for treatment of alcoholism and drug abuse, and so on.

Mr. PRICE. I am afraid I cannot do that in any detail. What we have——

Mr. CARTER. Are you not the coordinator of these groups? It seems you should know the intricate details of each one of these, if you are going to coordinate them and tell them what to do, and you are under a grant from NIH to do this.

Mr. PRICE. I am sorry, sir, we work with the State alcoholism agencies——

Mr. CARTER. Yes, sir.

Mr. PRICE [continuing]. To provide services to them.

Mr. CARTER. Do you visit any of the centers for treatment of alcoholism? Have you ever visited them?

Mr. PRICE. I have visited centers, yes sir, but it is not our primary function to work with local treatment programs.

Mr. CARTER. Yes, sir. Your primary function then is to coordinate groups for which you are not basically trained; is that correct?

Mr. PRICE. No, sir.

Mr. CARTER. I think you have a moral interest, certainly, but so far as your actual training is concerned. Are you trained for this?

Mr. PRICE. I am by experience.

Mr. CARTER. I compliment you on your moral approach. I wonder about the other.

Thank you, Mr. Chairman.

Mr. ROGERS. How often do you meet with your State people?

Mr. PRICE. We have two meetings a year and——

Mr. ROGERS. I presume you receive a large input from them?

Mr. PRICE. Yes, we have input from them constantly.

Mr. ROGERS. Your official meetings are twice a year?

Mr. PRICE. That is right. I think I would agree with your feeling that your experience has qualified you to work in the field of alcoholism treatment.

Mr. ROGERS. I don't know that I feel it is essential that we require professionally trained health personnel in all phases of alcohol treatment and rehabilitation. As I understand, there are many successful programs using rehabilitated alcoholics or individuals who have had long experience in the field.

Thank you so much for being here, and for letting us have this information.

Mr. PRICE. Thank you.

Mr. ROGERS. It has been most helpful.

The last witness is Mr. Arthur D. Pratt, National Association of Flynn Christian Fellowship Houses, Indianapolis.

I understand there was some mixup this morning on the panel, but you did want to make some specific points to the committee, and we will be glad to hear from you.

STATEMENT OF ARTHUR D. PRATT, PRESIDENT, NATIONAL ASSOCIATION OF FLYNN HOUSES, INC., EXECUTIVE VICE PRESIDENT, INDIANAPOLIS MUNICIPAL COURT ALCOHOLIC TREATMENT AND REHABILITATION PROGRAM

Mr. PRATT. Thank you, Mr. Chairman, Mr. Hefner.

My remarks primarily concern the homeless alcoholic with whom I have been dealing for 20 years as president of the Flynn Halfway House, and as director of two treatment programs.

The 1970 legislation, insofar as it influenced homeless alcoholics, primarily concerned the promotion of the Uniform Alcoholics Act which promulgated the removal of the alcoholic from the arrest system.

The objective of the accompanying statement with my statement. I presented a study we had made of the many studies made by NIAAA and other agencies of legislation having to do with homeless alcoholic treatment. So I am making references to that study from time to time.

Federal funds were paid to States for enacting this legislation.

The object of the accompanying study is to urge that a really thorough study be made of the results and costs of this legislation. I have sent researchers into Baltimore and Washington for the last 3 years, and our cursory studies indicate that this legislature is a disastrous failure. Here are our reasons:

Removing the homeless alcoholic from jails demanded the establishment of costly detoxification centers. Recidivism in these centers is tremendous. Alcoholics go into the center for 1 or 2 days, go out again and get drunk and return to the center again within a month.

Now, I would like to pause and say that my experience with the alcoholic shows that he first of all depends on his mother, then on his wife, and when they are done with him then he begins to depend on detoxification centers, and he becomes highly dependent upon these centers, he returns to them time and time again.

And I ran such detoxification center in Baltimore from 1958 to 1961. I detoxified 3,000 persons. I did a study of 300 of these persons. None of them had stayed sober. They had all returned time and time again to the facilities an average of 10 times a year, and I began to see

that I was actually adding to their problem by providing a way for them to sober up once they had gotten drunk.

I want to cite some other statistics. When the detoxification center was first founded here in Washington in 1968, they have their recidivism figures, those figures show that 45 percent of the persons who came in the first year returned five times or more to that center, so they were having exactly the same problem I had.

The third statistic—in Indianapolis yesterday I learned that our detoxification center is now experiencing 85 percent of the men as recidivists. I questioned their personnel and they told me many of these people are returning 20 times a year.

I am not asking the committee to accept my statistics, I am asking that a study be made of this problem, not by the NIAAA, that have promulgated this legislation, but by on objective body that will take a hard look at this and see if there is truth in what I am saying.

I will continue with my statement.

There are no statistics on long-term recovery of the alcoholics going to these centers. In my opinion, the reason for this is that there is no—or very little—recovery. Alcoholics require at least 60 days inpatient treatment, rather than 2 days in a detox center, to effect total recovery. Our statistics from the municipal court program in Indianapolis bear out this point.

We are showing men who are put on probation by the judge and sent into the 6-month treatment. At the end of that period 78 percent are sober. From the men who come voluntarily into treatment, plus the men on probation, we show only 38 percent sober at the end of 2 months.

So, we feel that there are very great advantages to the use of probation when it is combined with treatment. When the alcoholic is removed from the arrest system, the police tend no longer to pick him up on the street, resulting in his possible death from DT's or exposure—I was told by the Washington authorities here they knew of such deaths since decriminalization in Washington—and/or his becoming a public nuisance on the streets.

The detox centers cost a great deal of money and get little results. I would say that instead of decriminalization being reversed, that it be halted, and that we take a hard look at its results, I feel that an objective study is the prime thing that needs to be done. To go ahead and spread this legislation when there are grave questions as to its effectiveness, to me, is disastrous.

RECOMMENDATIONS

That decriminalization legislature be halted, that alcoholics be sent to jail and the jails themselves be used for detoxification with their own detoxification officers, and that the money now spent for detox centers be largely diverted to treatment programs that render at least 60 days inpatient treatment and 4 months outpatient treatment.

That police pick alcoholics up on the streets and that judges be advised to send alcoholics into treatment reinforced by at least 6 months probation. This point is central to our experience: Alcoholics stay in treatment and recover much better under the pressure of probation than when they come voluntarily. In 1975, the first quarter

statistics of the municipal court program show 78 percent of our alcoholics sober after an average 4 months period against only 38-percent recovery for our total population, including approximately two-thirds that came voluntarily. Mandatory treatment programs in Atlanta, Ga., appear to show the same results.

Now, I cite our experience in Indianapolis. There is one other place where this has been tried and that is Atlanta, Ga. It has been successful there, and I would refer those of you to the study of what they have done as well.

I further recommend that more funds be spent for alcoholic information programs which induce alcoholics to accept treatment. A study by Health Management Service, in Indianapolis, show 63,000 alcoholics in Indianapolis of which only 5,000 have become involved in all treatment programs, including Alcoholics Anonymous.

I think that is an extremely important matter. It seems to me that the vast number of alcoholics are still not accepting treatment of any type. There are women protected by their husbands in their homes, families that do not want to expose themselves to the public degradation of the problem who will not bring their alcoholics in for treatment. We must take a hard look at how we can bring people more effectively into treatment.

Finally, that more thorough efforts be made to collect exact statistics on deaths from alcoholism. For example, a recent study by a medical group of 1,000 accidental deaths in autos and at home, brought into the D.C. General Hospital, show that approximately 50 percent were legally drunk at the time of their death. The tendency of doctors not to record drunkenness or alcoholism as the cause of death—due to consideration of the family—obscures the tremendous fatality rate resulting thereform.

I would only like to add to this comment on Mr. Boche's testimony here. He said there had been a great improvement in reducing the number of persons being picked up on the streets in Minneapolis for public intoxication.

Now, we have had that sort of improvement in Indianapolis, too, while we have not decriminalized. I believe the reason for this improvement is the one that Mr. Boche stated, namely, that when you have a central collection agency—and you may want to call it a detoxification center—you get a far better placement system.

In Indianapolis, we have developed a placement system in which the Salvation Army, the missions, our treatment programs are all involved, and we are able to structure not only treatment but long-term custodial help for a homeless alcoholic, and that has reduced the number of arrests in our city, without decriminalization.

I think that unwittingly the detoxification centers serve as a better purpose as this type of collection agency than they do for detoxification, and my own recommendations to the committee would be that we greatly cut the medical personnel of these detoxification centers and use them largely for placement. Ours in Indianapolis does not need four RN's. It does not need three LPN's. It needs one professional with a number of paraprofessionals, and it can do an adequate job of detoxification and a far more important job of placing the persons in the types of structures that they need.

Those are the types of results that I would like to see come out of a study.

I also take very profound objection here in the intimation of some of the panel members that all treatment programs are more or less alike. I have traveled to many cities' founding halfway houses, and I find a tremendous difference ranges in the quality of treatment, and I think we ought to take a hard look at the quality of treatment, with the emphasis on long-term recovery and fund the programs that are working, and get rid of the ones that are not working.

[The attachment referred to follows:]

THE IMPERATIVE NEED FOR A STUDY OF LEGISLATION DECRIMINALIZING ALCOHOLICS, TREATMENT PROGRAMS ARISING FROM SUCH LEGISLATION, THEIR RESULTS AND COSTS (THE 1970 ALCOHOLISM TREATMENT ACT AND THE UNIFORM ALCOHOLISM ACT)

(By Arthur D. Pratt, 225 N. New Jersey Street, Indianapolis, Ind.)

At the conclusion of this paper, there is a lengthy bibliography of studies of the treatment of homeless alcoholics. After research on many of these studies, we find that they are distinguishable by three glaringly important facts:

1. With the exception of the St. Louis Study,[1] there are no statistics on long-term recovery from alcoholism achieved by federally financed treatment programs. (In St. Louis, 19% of the men treated showed significant improvement, though not all of these persons had stayed sober.)

2. With the exception of the Report, "Comparison of Three Detoxification Centers During the First Year of Operation,"[2] there are no statistics on how frequently alcoholics returned to programs for treatment (the recidivism rate). However, in "Comparison of Three Detoxification Centers During the First Year of Operation," the Washington, D.C. Detoxification Center shows that 45% of the men treated returned to the Center for detoxification five times or more during the first year.

3. There is no adequate knowledge of the exact cost of these programs.

There is an urgent need for a study to produce these statistics on alcoholic treatment for the following three reasons:

(1) Death rate. Most homeless alcoholics do not recover but die of their condition. In my experience in treating over 10,000 alcoholics in the last 19 years, I (Arthur Pratt) estimate that no more than 2% achieved total sobriety. The vast majority dies slowly of their condition. If this can be proven statistically, it should be a public fact of the first importance, warning that alcoholism is indeed a deadly killer much more widespread and lethal than all other drug addiction. Also, such statistics would expose the fact that our present methods of treatment are inadequate.

(2) Results. Current legislation decriminalizing the alcoholic and consequently transferring his detoxification from jails to Detoxification Centers may be a tremendous failure. The results of the Washington Detox Center, mentioned above, would indicate a failure. In the Baltimore Flynn House, we detoxed 2,000 men in the period of 1958–61. Then we made a sample study of 300 of these men. All 300 had gotten drunk, many returning innumerable times to our facility. They were getting drunk with the assurance that we would detoxify them.

In lieu of 2 days detoxification, we now feel that 60 to 90 days inpatient treatment is far more successful. Statistics on the above points could guide us on whether to spend public funds on Detoxification or on In-Patient Treatment. There is an indication that studies do not show long term results in terms of sobriety because these results would be negative.

(3) Costs. After discriminalization in Maryland, $700,000 a year was being spent in Baltimore alone in 1973 for Detoxification and Follow-up services. After detoxification, alcoholics were sent to the three Mental Hospitals near Baltimore, occupying a very large number of beds at approximately $30.00 a day per man bed. Since these men could leave voluntarily, they frequently left prematurely—without appreciable recovery—only to return again drunk in a few weeks. I estimated the costs for these services for the State of Maryland at a minimum of $10,000,000 for the year 1973.

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[1] J. Weber, Final Evaluation Report, "The St. Louis Detoxification and Diagnostic Evaluation Center."

[2] "Comparison of Three Detoxification Centers During the First Year of Operation." Division on Alcoholism, Indiana Department of Mental Health.

Raymond T. Nimmer, in his study of taking the Public Inebriate out of the Criminal Justice system for the American Bar Foundation entitled *Two Million Unnecessary Arrests*,[3] discussed the experiment in detoxification centers in St. Louis. He says that the staff consider rehabilitation as "crucial"; he goes on to add, "while we are not prepared to say that the detoxification center is merely a re-labeled version of the revolving door, its apparent failure to establish rehabilitation success is important. The program is costly and spends approximately forty-one dollars per patient per day." The statistics in the study point out that the cost of the program, even after subtracting criminal/justice savings, resulted "in a new increase of expenditures of almost $150,000."

Now, the point is: After considerable research, we find no study firmly determining these costs and relating them to the results obtained from these programs.

THE INADEQUACY OF PRESENT FEDERAL STUDIES

Look at what is bound to become a classic in government "white papers" as it brings a new tool to measure success: the computer projection of cost comparisons. The machine that can't be wrong says that we'll save a lot of money ten years from now if we spend a lot now. The Human Ecology Institute under the sponsorship of NIAAA made a cost analysis of treating Alcoholics in Baltimore and Atlanta, "Costs for Alternative Public Inebriate Services."[4] They feed the material into a computer and let its circuits project the costs for the next several years, and then from this information human beings drew some conclusions. The results could be summarized: Eliminating the alcoholic from the criminal justice system will not cut its costs, but may keep it from having to expand: the best alcoholic treatment is a Co-ordinated system of services; the larger the system the more persons it can serve; the more people served the more rehabilitation; the more rehabilitation the greater the savings. The people who inhabit George Orwell's novel "1984" with its "Newspeak" would be proud of this effort.

To reiterate, there is an imperative need for an objective federal study showing the results of decriminalization of alcoholics and of its allied treatment programs and the cost of such programs. Such a study should not be made by the NIAAA which sponsored decriminalization legislation and its resulting programs but by a Congressional Committee.

A bibliography of studies referred to in this paper, plus other important studies, follows.

ADDITIONAL REFERENCES

1. Task Force Report: Drunkenness, the President's Commission on Law Enforcement and Administration of Justice, U.S. Printing Office, 1967.

2. Proceedings of the Seminar on Alcoholism Detection, Treatment and Rehabilitation with the Criminal Justice System, October 18, 1973, LLEA.

3. Journal of Studies on Alcohol, 1974–1975, the Center of Alcohol Studies, Rutgers University.

4. "From Damned Drunk to Alcoholic—By God and By Law," Gertrude L. Nelssow, ACSW, Division of Alcoholism Control, Maryland Department of Mental Hygiene.

5. Uniform Alcoholism Act, U.S. Congress (the basis of decriminalization legislation).

6. Statistics Relative to 2,836 Patients Admitted to the Rehabilitation Center for Alcoholics, Occoquan, Virginia, August 21, 1967 through September, 1970. James A. Vanderpool, Ph. D., Clinical Director, Rehabilitation Center for Alcoholics, Occoquan, Virginia (Central Washington, D.C.).

7. Detoxification, Decriminalization, and the Criminal Justice System. Boston Alcohol Detoxification Project, LLEA.

8. The Impact of Decriminalization on the Intake Process for Public Inebriates, First Project Report, December 23, 1974, LLEA.

9. Detoxification, Decriminalization and Criminal Justice System in the City of Boston (1975), LLEA.

10. Revolving Door: A Functional Interpretaion, Alcoholism and Drug Addiction Foundation (1966).

[3] "Two Million Unnecessary Arrests," Raymond T. Nimmer, American Bar Foundation.

[4] Three studies are involved here, all by the Human Ecology Institute:
(a) Alternative approaches to the Public Inebriate Problem in Two Metropolitan Areas: A Summary
(b) Cost of alternative Public Inebriate Services: Baltimore, Maryland.
(c) Cost of alternative Public Inebriate Services: Atlanta, Georgia

11. Revolving Door: A Study of the Chronic Police Case Inerbriate, D. Pittman and C. W. Gordon (1958).
12. The Chronic Drunkenness Offender in Connecticut, E. Lisansky (1967).
13. The Misdeamant Offender in Illinois, H. Matlick and K. Chuseel (1967).
14. Alcohol Problems: A Report of the Nation, T. Plant (1967).
15. Alcohol, Alcoholism and Law Enforcement, D. Gillespie, editor (1969).
16. The Chronic Drunkenness Offender: Physical Condition, J. Olin (1968).
17. Society, Culture and Drinking Problems, D. Pittman and C. Snyder, editors (1962).
18. The Chronic Drunkenness Offender: The Courts, P. Giffon (1966).
19. The Drunkenness Offender: T. Cook, D. Gadby and E. Hensmen, editors (1969).
20. Philadelphia Skid Row: A Demonstration in Human Renewal, Blacker (1967).
21. Hospitals Replacing the Drunk Tank in St. Louis, S. Auerbach (1960).
22. Evaluation of the Emergency Care Program for Acute Alcohol Intoxication at the Detoxification Center, Washington, D.C., C. Weyman and A. Riordan (1970).

Mr. ROGERS. Thank you very much.

Mr. Hefner?

Mr. HEFNER. I have no questions, Mr. Chairman.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

You paint a bit of a gloomy picture of an alcoholic; is that correct?

Mr. PRATT. I would like to be honest in saying I do not believe that there is 2 percent recovery of alcoholism in the United States. I think most of the people afflicted with this illness are dying of it. I think the sooner the public knows that perhaps the sooner people will see how dangerous alcohol is, and be willing to treat it with more temperance than they are at the moment.

Mr. CARTER. Perhaps we should put more emphasis on prevention. What do you feel?

Mr. PRATT. I have stressed in my statement that imaginative ways to treat prevention, I think are very important, and I think they should be funded.

Mr. CARTER. I know in St. Louis you stated that 19 percent evidently, had shown improvement, approximately all of them did not stay sober or part of them at least did not stay sober; is that correct?

Mr. PRATT. That is right. I think that the persons who talk about, as Mr. Boche did, improved functioning as a criteria for recovery are somewhat selling themselves down the river. If an alcoholic improves his job relationship somewhat, if he improves his family relationship but he still gets drunk, he is going to destroy the improvement that he made.

So, improved functioning I do not hold with as a very good criteria for success. I hold with total sobriety as such a criteria. I think it can be achieved through the sort of excellence of treatment that we have developed in Indianapolis, and some other cities have developed.

Mr. CARTER. And in Washington, D.C., 40 percent of the men treated returned to the center for detoxification five times during the first year; is that correct?

Mr. PRATT. That is a statistic apparently published by that center and appearing in the study "Comparison of Three Detoxification Centers During the First Year of Operation", published by the Division on Alcoholism, Indiana Department of Mental Health.

Mr. CARTER. Yes, sir. These are rather tough statistics. They do not show much improvement in our alcoholics, or their ability to "kick the habit with help", if we should put it that way.

It is a pretty sad state. However, I think you have been perfectly frank with us and fair.

Thank you, Mr. Chairman.

Mr. ROGERS. Let me ask you now, as I understand it, you are saying that Indiana still recognizes alcoholism as a crime?

Mr. PRATT. Recognize it as what?

Mr. ROGERS. As a crime—it is still classified as a crime in your State, as I understand you to say?

Mr. PRATT. Yes; a misdemeanor.

Mr. ROGERS. Now, can you describe your exact treatment program? I know you bring them in and detoxify them, and have an inpatient treatment.

What is it you do?

Mr. PRATT. As I stated this morning——

Mr. ROGERS. You may remain seated.

Mr. PRATT. I would prefer, if I might, to stand.

Mr. ROGERS. Certainly.

Mr. PRATT. We have experimented with many forms of treatment, and we have found that the psychological treatment program developed under transactional analysis extremely effective in the recovery of alcoholics. We have a number of men now sober 2 to 3 years, and showing a great deal of the emotional and intellectual maturity that we feel earmarks total recovery from alcoholism.

We feel that emphasis on programs which say that vitamins are going to effect recovery from alcoholism or that biological incentives are going to is mistaken. We have tried many of these and now feel the problem is largely psychological in its nature.

The treatment involved in both A.A. and transactional analysis, brining a person to recognize the nature of their own problems, and making decisions themselves about the reversal of these problems works best. This is why I have great reservations about any biological approaches to the problem. I think that alcoholism is a self-induced illness and I think the person who has it must make decisions himself about his own recovery. It is the role of the therapist to help them make those decisions, not to impose those decisions upon them.

Mr. ROGERS. But what I am asking is, what does your treatment program consist of? Could you just explain it for us so the committee would have the benefit of knowing what you are doing in Indianapolis?

Mr. PRATT. We give 30 to 60 days of inpatient treatment.

Mr. ROGERS. Where is that given?

Mr. PRATT. We have two treatment centers; 25 to 30 men are treated in one of thse centers. These are what were called therapeutic communities. That is, everybody involved in the centers treats one another and paraprofessionals (recovering alcoholics trained as therapists) have a great deal of functioning in this.

Mr. ROGERS. Do you use former alcoholics in the treatment program?

Mr. PRATT. We use almost exclusively former alcoholics and they are trained paraprofessionally.

Mr. ROGERS. Who trains them?

Mr. PRATT. We have a combined training in which Indiana University School of Psychology and Christian Theological Seminary, which sponsors a program of treatment based around transactional analysis participate plus our own training porgram. We have all three of these for the training of paraprofessionals.

Mr. ROGERS. Do you try to help them rehabilitate themselves in this transactional——

Mr. PRATT. Transactional analysis.

Mr. ROGERS. Is there a religious basis to this type of analysis.

Mr. PRATT. No; transactional analysis is purely a psychological program. We refer persons to A.A. for spiritual help.

Mr. ROGERS. So you keep them for a period of 30 to 60 days?

Mr. PRATT. Yes; and we have constantly expanded the time. We started with 15 days, 2 years ago went to 30, now we are at 60, and we feel that perhaps even a longer period. We have 6 hours a day of intense psychological training, including what is called confrontation therapy, psychodramas, all aimed at self-understanding plus understanding of the influence of parents. Parents have a great deal to do with the formation of alcoholism. We find that with many alcoholics, their fathers were alcoholics, too.

Mr. ROGERS. Could I ask a few questions to get it in my mind?

You first would detoxify them, or do you?

Mr. PRATT. We have done it—but is a very small part of the treatment.

Mr. ROGERS. I understand. But when they come to you drunk, do you detoxify them first?

Mr. PRATT. Yes; we have detoxified them, and we have used our detoxification center in Indianapolis.

Mr. ROGERS. Then you keep them in inpatient treatment for 60 days?

Mr. PRATT. That is right.

Mr. ROGERS. And they are given psychological help?

Mr. PRATT. That is correct. We also, sir, give them a complete physical examination and treat any physical illness they have.

Mr. ROGERS. During the inpatient treatment phase?

Mr. PRATT. We also use high protein diet and vitamin therapy. Those things are much less important than the psychological.

Mr. ROGERS. I understood you. Now, at the end of 60 days, what happens?

Mr. PRATT. We have a placement service in which we help them to get employment. We have them return to our center for continuing outpatient treatment for 4 months. We also work with their families so any family problem might be readjusted.

Mr. ROGERS. And what is the cost of that program?

Mr. PRATT. The cost is a little less than $5 a day per patient, and the reason for this is the extensive use of paraprofessionals and the use of our other city agencies to cut down the expenses.

The average cost in a mental hospital for the treatment of alcoholics is $38 a day. We feel that this form of treatment is much less expensive, and is more successful. The budget, of course, being based upon the use of paraprofessionals.

Mr. ROGERS. Now, who pays for this?

Mr. PRATT. We receive $1 by State legislation from every Municipal Court fine in Indianapolis, so the alcoholics pay a lot themselves, because people arrested for public intoxicated are paying $1 from their fines.

In our halfway house facilities, our program is strictly: You must work, you must pay $25 a week for your room and board. We stress this with our alcoholics and all 32 of the halfway houses, of which I am president, operate in this manner. We derive about 80 percent

of our income from this payment of $25 a week. The balance is given to us by concerned individuals and occasionally we will use State moneys but we are reluctant to do so.

Mr. ROGERS. Now, are they assigned to you by the court?

Mr. PRATT. Mr. Chairman, when the court assigns them to us, when the judge says "Look, you have five drinking arrests and I think it is time for you to accept treatment, don't you?" The man smiles and says "yes." And the judge says "All right, I am going to put you into treatment, you will be on probation 6 months. If you drink in this time you will be picked up and incarcerated." When this happens, the alcoholic is most likely to stay and treatment to succeed.

What happens, after this, is that it takes about 1 month for that man to really begin to take hold of himself. It takes about that period of time for him to understand that he truly can recover. The biggest problem, gentlemen, is that the alcoholic is defeated. He has a great deal of guilt. He does not really believe he can recover, and so the first month of treatment is aimed at convincing him that he can do so.

After that you begin to get tremendous personality changes, great enthusiasm, the fact that the judge sends the person makes a great difference.

Mr. ROGERS. Do you have any recidivism in the 78 percent that you cure after 4 months?

Mr. PRATT. We do have some but it is not nearly as high as we had before we adopted these treatment techniques.

Mr. ROGERS. Has a study been made of that?

Mr. PRATT. No; and we would like to be included in any studies that are made.

Mr. ROGERS. I wondered if you had done a study on what the recidivism rate is.

Now, as I understand it, you do favor mandatory treatment?

Mr. PRATT. We only favor it because we found that it works best. I was very much for decriminalization in my early career in this field, and it was only through hard experience that I changed my viewpoint. I know 10,000 alcoholics personally, and have treated them. I learned that they very frequently walk out within the first 2 weeks of treatment when they come voluntarily, and so I had to reverse my concept of taking the alcoholic out of the arrest system because I found that the arrest system was actually valuable in mandating probation and keeping the man in the treatment.

I would like to refer you to the Wall Street Journal of last month in which a group of industries are using exactly the same technique. They are saying to alcoholics "we are going to fire you unless you accept treatment," and they are getting a 70 percent treatment recovery.

The use of the law, the positive use of the law, is a very rehabilitative factor.

Mr. ROGERS. Well, I just thought it was interesting that you claim a certain rate of cure while at the same time the Minneapolis program, which is not compulsory, also claims a rather significant result.

Now, let me ask you this.

How is it with the success of this program you still are only reaching 5,000 out of 63,000 alcoholics in Indianapolis?

Mr. PRATT. That is an excellent question, Mr. Chairman.

We are, as I said in my statement, dealing with homeless alcoholics These are the men who are arrested time and time again. In Indian-

apolis they constitute a population of about 2,000 derelict persons. They are arrested four or five times a year. The vast number of alcoholics unreached by any treatment programs are not arrested that way. They are middle class persons protected by the police and their families.

If a middle income person is found on the street drunk, the policeman often takes him home. The protection of the alcoholics' wife, or if it happens to be a woman, her husband shields her from this type of arrest, and this is why you had this disproportionate statistics that you observed.

Mr. ROGERS. Then, is the fact that because in Indiana alcoholism is a crime, it is a prohibiting factor to coming in for treatment?

Mr. PRATT. No; to no significant extent.

Mr. ROGERS. What I am suggesting is that there would be no need to shield alcoholics from arrest, and thus treatment, if alcoholism were decriminalized.

Mr. PRATT. I think Mr. Boche has said that there is some indication——

Mr. ROGERS. I was thinking of your situation where you say you are not reaching a vast number of alcoholics because they are shielded from the law that makes alcoholism a crime.

Mr. PRATT. I think perhaps a small percentage are influenced in that way. I imagine that a very large percentage are not influenced at all. They do not dream of being arrested.

I do know this. That one of our leading alcoholics in Indianapolis, who is a doctor, makes this statement. He said that the first time he was arrested was the critical moment at which he admitted his problem.

In other words, it took this kind of experience to shake him loose and really help him to face himself.

Mr. ROGERS. Evidently that is not necessarily true in other parts of the country because we are having many come into treatment programs voluntarily.

Mr. PRATT. We have many, of course, come in voluntarily to us. The problem is that they do not stay.

However, Mr. Chairman, I think that there is some validity in the point that you are making, and I personally would like to see an objective study of that.

Mr. ROGERS. Yes; I wanted to clear that up.

Let me ask one question and I will conclude. You commented that imaginative prevention programs would be good.

What are some examples of imaginative prevention programs?

Mr. PRATT. Well, possibly just the realistic admission of the tremendous death rate and the proper use of that type of statistic.

Mr. ROGERS. Education then is what you mean by prevention?

Mr. PRATT. Yes; I think we have many young people coming in ot our program that have been on drugs and are shifting to alcohol because they find that they don't get busted—I am using street language.

Mr. ROGERS. We understand that.

Mr. PRATT. They do not get busted when they are on alcohol.

To take a drink at the high school level is a sort of noble act, you are one of the boys, everybody is doing it, et cetera.

But the use of a good statistic on death rates might get young people to really reflect on what they are facing when they do use alcohol.

Mr. ROGERS. Do you have any other ideas on good prevention approaches?

Mr. PRATT. Of course, the creative use of alcoholic information centers. I was at the National Association's meeting in Amsterdam, Holland 2 years ago and I found that in England for example, they have alcoholic information centers that very extensively use television and other sources. We are going to start to do that in Indianapolis. We put on a dramatization of an alcoholic and his wife in the sort of mutually destructive situation that builds up and put that sort of thing on TV.

Let people see the profound nature of this problem. Of course, intensive use in high schools of alcoholic speakers is another very good tool that can be used.

I think those things generally are like the treatment programs; they must be done with great care and with great imagination.

Mr. ROGERS. Thank you for being here. You have been most helpful to the committee.

Mr. CARTER. Of the Federal moneys spent on alcoholism, how much do you feel goes for treatment and how much for administration?

Mr. PRATT. Well, I can tell you what we pay. Our program in Indianapolis costs $130,000 a year. Our professionals, of which there are three full time and one part time, get $36,000. Our paraprofessionals and the actual cost of food and so forth get the other $94,000.

Of course, I am very wary about the use of professionals in this area. I have that very grade reservation about their effectiveness. I feel very grave reservations about the building up of bureaucratic administrations that seem to me to be overcompensated.

Mr. CARTER. Would you think that some of them had delegated particular people as "grants men," to come here to Washington for increased grants?

Mr. PRATT. Possibly. I was very disappointed this morning that there was no more specific talk about what really needed to be done. It seemed to me nearly everybody testifying was the sort of person you are talking about, advocating appropriating a lot of Federal money. I was shocked that they were not more willing to say "I think that we do need to study detoxification, I think we do need to study the quality of the treatment."

People who have high religious motivations in this work ought to have the integrity to speak out and say where we are failing, and why we need to take a much harder look.

I was shocked this morning, and I went away sick.

Mr. CARTER. Has it been your observation that whenever we set up a bureaucracy for whatever purpose it might be, that immediately there comes forth an organization to support authorizations and appropriations for that particular group?

Mr. PRATT. Yes; but I think we desperately need an organization with integrity that can look not only at the need, but also at the costs of the need, and I would not recommend the increase from $200,000 to $300,000. I want to know how well we are doing with this program. I am disappointed. I think before putting that kind of money into this, you gentlemen deserve to know what is being done here.

Mr. HEFNER. I think I mentioned this morning the fact that a volunteer, whether it be a drug junkie or former alcoholic, in many cases

is much more effective in group therapy than some highly paid person with a theory.

Now, is that what you are saying to us? That you can use the people who have been on the streets and who have been rehabilitated to tell their story to educate, and that many times the prevention would cost you the same as the cure?

Mr. PRATT. I think you hit the nail on the head.

Alcoholics Anonymous is completely run by recovering alcoholics. Our halfway houses are completely run and financed by recovering alcoholics. Eight of the eleven staff members on our treatment program in Indianapolis are recovering alcoholics. So I think that a great deal of the evidence bears out what you say.

I would also say this to you, gentlemen, that if you combine your drug and alcoholic programs together administratively, I think that you will save money and be as effective. We find that one-third, 50 percent of our alcoholics, are also addicted to drugs, that the program of treatment is equally applicable to both. And to me, to have the two agencies separated is a waste of public money.

Mr. HEFNER. Do you think it would be educational to a point to show the gory details of automobile accidents caused by drunk drivers that take the life of a father or a mother? We show everything else on television. Why do we not show the gory side of alcoholism as well as showing what the beautiful people are doing with alcohol?

I feel very strongly on this line. I think that would be very educational and very awakening and very shocking to the people. Why do we not show it and let the people decide in many cases for themselves what the consequences can be?

Mr. PRATT. You know, I agree with you and I also think there is a disguising of the true nature of the alcoholic when you talk about alcoholism simply as a disease.

I have dealt many, many times with the abandoned wife and children of alcoholics who literally dropped them, placed them on welfare. I have dealt many times with employers who have had alcoholics walk out on them, ruining their equipment.

To simply define this condition as an illness when there is that sort of irresponsible conduct, and to gloss over this antisocial behavior that the alcoholics has is not a realistic view of the person's true condition.

Mr. ROGERS. Thank you so much, and the committee is grateful to you for being here.

This concludes the hearings for today. The committee stands adjourned until further notice.

[Whereupon, at 3:45 p.m., the subcommittee adjourned to reconvene at the call of the Chair.]

COMPREHENSIVE ALCOHOL ABUSE AND ALCOHOLISM PREVENTION, TREATMENT, AND REHABILITATION ACT OF 1970—EXTENSION

MONDAY, JANUARY 26, 1976

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10:30 a.m., pursuant to notice, in room 2325, Rayburn House Office Building, Hon. Paul G. Rogers, chairman, presiding.

Mr. ROGERS. The subcommittee will come to order. The subcommittee will conclude its hearings with respect to the provisions of H.R. 11317, which would extend the programs of assistance under the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 by receiving testimony from administration witnesses.

This is the first subcommittee hearing since the release of the President's budget for fiscal year 1977, which proposes the termination of some 17 programs developed by the Congress over the years, including the alcohol program, and replaces all 17 with a block grant program for the States. This subcommittee will be interested in the administration's justification of this decision.

This morning we are pleased to have as administration witness, Dr. Theodore Cooper, who is the Assistant Secretary for Health, accompanied by Mr. James Isbister, Administrator of ADAMHA. I believe we have Dr. Endicott, HRA Administrator listed, but I don't see him. Dr. Martin Cummings, Director of the Library of Medicine. Mr. Gene Haislip, Deputy Assistant Secretary of Legislation.

Good to see you. If there are others, we will let you identify them.

STATEMENT OF THEODORE COOPER, M.D., ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY JAMES D. ISBISTER, ACTING ADMINISTRATOR, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION; ERNEST NOBLE, M.D., DIRECTOR-DESIGNATE, NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM, ADAMHA; JOHN DEERING, M.D., ACTING DIRECTOR, NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM, ADAMHA; AND GENE HAISLIP, DEPUTY ASSISTANT SECRETARY OF LEGISLATION (HEALTH), DHEW

Dr. COOPER. I will be pleased to identify and introduce the others.

Mr. ROGERS. And I might say your statement will be made a part of the record [see p. 221], without objection.

Dr. COOPER. Mr. Chairman, I would suggest that you allow me to submit the statement for the record in their entirety, and we will spend what time available you have for discussion of some of the issues.

Mr. ROGERS. All right, sir.

Dr. COOPER. I would like to introduce, in discussing the question of the extension of the alcohol activities, Dr. Deering, the Acting Director of the National Institue on Alcohol Abuse and Alcoholism, and also Dr. Noble, the Director Designate, who will be on board with us full time soon. We are delighted to have him with us, and we are delighted to have been able to recruit him.

Mr. ROGERS. Dr. Deering and Dr. Noble, we welcome you to the committee.

Dr. COOPER. As we get on to the other problems, I will introduce some other program leaders who are here with me. But these, as you have indicated, are two separate kinds of issues that we need to discuss this morning.

In discussing the alcohol programs and our progress on alcoholism, I think the first point I would like to make is that we do recommend extension of the activities. We think alcoholism is a very serious public health problem that has been increasing in the past years.

We think that implementation of the Federal activities under the various authorities since 1968 and so on have had impact. They have generated not only awareness, but some comprehensive activities that have begun to show impact on control of the problem, on prevention in key target population groups, other understanding of the biological implications of excessive alcohol intake, and the like. All of these were areas that did and still do need attention, and we do recommend continuation of the activities.

I could spend some time, but I would just refer you to page 5 in the testimony which describes some of these measurements of the program. I do not want to spend all of the time saying the good things that have been measured, although I do want to call them to your attention. At the same time, I would acknowledge——

Mr. ROGERS. I think it might be well to go over those, if you don't mind.

Dr. COOPER. All right, I will be pleased to discuss several of these points because it does underscore the notion of our appreciation of the importance of the problem, and the fact that despite some difficulties in implementing a very complex program, there has been progress.

Now, I think as we have pointed out here, alcoholism is now being more and more accepted as a health problem, as opposed to a criminal issue. Twenty-seven States have now adopted the Uniform Alcoholism and Intoxication Treatment Act; 16 of these States have received special grants for implementation of the act.

Public interest, generated in part by two major NIAAA congressional reports synthesizing research knowledge in the alcohol field, has been amplified by widespread public education campaigns. The social stigmas attendent to the illness of alcoholism appear to be lessening. There are now an estimated 500 national voluntary citizen and youth organizations involved with the alcohol problem.

Since 1970, there has been a tenfold increase in outreach programs by businesses to assist affected employees. There are more than 275 occupational programs serving 2,750,000 people.

Among the programs for special target populations, the Institute has supported 160 projects originated and run by Indians.

In conjunction with the Department of Transportation's alcohol safety action program, special treatment programs have been supported.

Technical assistance has also been provided to enable treatment and rehabilitation projects to become self-sufficient and able to collect third party payments. In addition, NIAAA has initiated activities that are leading to an expansion of health insurance coverage for alcoholism.

A National Clearinghouse for Alcohol Information has been established. Its library and reference system contains more than 45,100 items, and some 8.5 million information items have been disseminated throughout the Nation and the world.

In total over 750 prevention, treatment, and rehabilitation projects across the Nation have been funded.

Now these are some of the things that we report to you.

We are aware that some of the other witnesses last week reported some of the other biological facts of good trends in understanding the biological impact of alcoholism and, supported by the research activities, the impact of providing training for people. We basically are pleased with the trends that all of this activity has produced.

Now, the administration proposal, as you have already mentioned in your opening statement, is to include the community and service aspects of these activities in what is now called the block grant proposal in its jargon, but which is called the Financial Assistance for Health Care Act, which we will be submitting.

Mr. ROGERS. All right.

Dr. COOPER. In the near future.

Mr. ROGERS. I think it will be well to go over this portion of the testimony so the committee could better understand your proposal.

Dr. COOPER. Very good. I will begin on page 7.

It would seem reasonable that having made strides toward overcoming the problem of alcoholism and alcohol abuse and having demonstrated alternative approaches to dealing with it, we now must begin to enhance the capacities of the States and localities to deal with the problem at their levels—in the context of the regular community care system, through the financial assistance for health care program.

Under our proposal, Federal grantees will be guaranteed—from the States—a percentage for the first 3 years of the program of what they received in 1976 from the Federal Government. Grantees will be guaranteed at least 80 percent of their fiscal year 1976 grant level in the first year, 50 percent in the second year, and 25 percent in the third year.

I would like now to briefly discuss the proposal which we are preparing to introduce. It will include the present alcoholism program with a number of other current categorical authorities as part of a single major administration initiative in the health care area. The implementing legislation is to be known as the Financial Assstance for Health Care Act and is being designed to accomplish the following goals:

Distribute Federal health dollars more equitably to those persons most in need;

Allow each State to set its own priorities for health programs based on the particular needs of its population and its resources;

Give States the leverage and motivation necessary to control rising health care costs; and

Reduce Federal redtape and constrain the growth of Federal employment.

Under our proposal, funds will be distributed to the States according to a formula to be based on the poverty population in the State, per capita income, and the State's tax effort.

The States would be able to spend their allocations for a broad range of services, including those now covered by medicaid, and other HEW grant programs, for the provision of medical outreach and referral services, for home health aide services, and for living arrangements that would adequately substitute for institutional care.

A major feature of the legislation will be a requirement that States spend at least 90 percent of the funds on personal health care services. The States will set their own requirements as to eligibility and the benefit package but will have to focus their efforts on the poverty population.

A minimum of 5 percent of the Federal supplement will be earmarked for community and environmental health, specifically for community-based mental health services including alcoholism and drug abuse, and for community health protection—for example, disease control, environmental health, food inspection, and health education.

We will insert a provision which requires the States to address the folowing goals in their services plans:

Assurance to all citizens of the State, and particularly chronically underserved populations, of equal access to quality health services;

Development and utilization of preventive health services;

Prevention or reduction of inappropriate institutional care by providing for ambulatory, home-based care or other forms of noninstitutional services particularly for the age and disabled;

Encouragement of use of ambulatory services in lieu of inpatient services;

The provision of primary care services for medically underserved populations and those which are located in rural or economically depressed areas;

Appropriate, effective and efficient utilization of existing facilities and services; and

Promotion of communitywide health efforts.

Within the plans, the States will be required to submit a quantitative assessment of their needs and resources to provide the framework for assuring the efficient and effective use of Federal funds.

Mr. Chairman, I want to stress that we are offering a realistic alternative to the proliferation of isolated, narrow categorical health care programs that we have seen in recent years—programs that are gradually becoming more costly to administer at the expense of the services they are designed to provide—programs that are frequently inappropriate for some local needs and inadequate for others. Therefore, we recommend that this subcommittee support the proposed Financial Assistance for Health Care Act.

Accordingly, we are opposed to H.R. 11317. Notwithstanding our basic disagreement with the conceptual approach of H.R. 11317, we must point out that its total annual authorization levels of $188 mil-

lion are excessive. If the financial assistance for health care program is not enacted, we would strongly recommend a total authorization level of about $79 million which is consistent with the President's 1977 budget and adequate to meet existing Federal commitments to these programs.

I do have attached to the testimony, Mr. Chairman, members of the committee, a fact sheet which goes into considerable detail to the specifications of the Financial Assistance for Health Care Act, which is the core of our proposal to deal with many of these points.

I would be pleased to try to answer any questions which you or the other members of the subcommittee may have.

[Testimony resumes on p. 231.]

[Dr. Cooper's prepared statement and attachments follow:]

STATEMENT OF THEODORE COOPER, M.D., ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. Chairman and members of the subcommittee, I am pleased to appear before you today and to present our views on H.R. 11317, a bill to extend the programs of community assistance under the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 as amended.

H.R. 11317

H.R. 11317 would provide—starting with fiscal year 1977—a straight three-year extension of the 1970 Act, as amended—i.e., continuation of the formula grant program at authorization levels of $80 million; continuation of authorities to implement the Uniform Alcoholism and Intoxication Treatment Act at $13 million levels; and continuation of the community-based project grants and contracts at $95 million levels.

As you know, the Administration disagrees with the narrow categorical program approach within the health delivery system because we believe it inequitably singles out for special Federal assistance certain segments of the population or certain communities from many others similarly situated with equal or greater need for assistance. Likewise, it inhibits needed discretion in selecting local priorities and in devising effective means of carrying out programs.

We have long maintained that the Federal Government should provide general financing through programs such as Medicare and Medicaid and allow the States and localities the flexibility to develop and support health delivery services which are tailored to the particular needs of each area.

FINANCIAL ASSISTANCE FOR HEALTH CARE ACT

Today we come to you with what we believe is an innovative and positive proposal—the Financial Assistance for Health Care program—to accomplish our goals. We recognize that there may exist a philosophical difference between our approach and the approach reflected in H.R. 11317. However, we strongly believe that the Finacial Assistance Health Care proposal is a more equitable and appropriate way for the Federal Government to assist States and localities in meeting the health needs of the low income and other population groups. Programs such as the one you are considering now which have contributed in meeting specific health care needs in this nation would be continued at State and local discretion pending enactment of the proposed health block grant which would include the existing alcoholism programs.

With respect to our new proposal, I am attaching copies of a paper which indicates the major elements of our approach. Before discussing them, however, I would like to briefly review with you the highlights of the Department's alcoholism program to date.

BACKGROUND HISTORY

Most Federal alcoholism treatment authorities were originally established by the Alcoholic and Narcotic Addict Rehabilitation Amendments of 1968, and subsequently expanded by the Community Mental Health Centers Amendments of 1970 (P.L. 91-211). In December 1970, the Comprehensive Alcohol Abuse and Alco-

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holism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616) authorized a State alcoholism formula grant program and created the National Institute on Alcohol Abuse and Alcoholism within the National Institute of Mental Health. This Act was subsequently amended and extended in May 1974, by the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974 (P.L. 93-282) which (1) added provisions for a program of special grants to States to implement the provisions of the Uniform Alcoholism and Intoxication Treatment Act, (2) increased and extended the authorization levels for formula grants to States and community assistance project grants and contracts, and (3) established the National Institute on Alcohol Abuse and Alcoholism as a bureau level component of the Alcohol, Drug Abuse, and Mental Health Administration organizationally and programmatically equal to the National Institute of Mental Health and the National Institute on Drug Abuse.

PROGRAM ACTIVITIES

Since its creation in 1971 the National Institute on Alcohol Abuse and Alcoholism (NIAAA) has funded a wide range of demonstration community-based treatment and prevention activities.

Over the past five years, there have been substantial accomplishments in the area of Alcohol:

Alcoholism is now more identified as a health problem, as opposed to a criminal issue, in 27 States which have adopted the Uniform Alcoholism and Intoxication Treatment Act. Sixteen of these States have received special grants for the implementation of the Act;

Public interest generated in part by two major NIAAA Congressional reports, synthesizing research knowledge in the alcohol field, has been amplified by widespread public education campaigns. The social stigmas attendant to the illness of alcoholism appear to be lessening. There are now an estimated 500 national voluntary citizen and youth organizations involved with the alcohol problem;

Since 1970 there has been a ten-fold increase in outreach programs by businesses to assist affected employees. There are more than 275 occupational programs serving 2,750,000 people;

Among the programs for special target populations, the Institute has supported 160 projects originated and run by Indians;

In conjunction with the Department of Transportation's Alcohol Safety Action Program, special treatment programs have been supported;

Technical assistance has also been provided to enable treatment and rehabilitation projects to become self-sufficient and able to collect 3rd party payments. In addition, NIAAA has initiated activities that are leading to an expansion of health insurance coverage for alcoholism;

A National Clearinghouse for Alcohol Information has been established. Its library and reference system contains more than 45,100 items, and some 8.5 million information items have been disseminated throughout the nation and the world;

In total over 750 prevention, treatment and rehabilitation projects across the nation have been funded.

The accomplishments listed above reenforce our belief that States and localities are ready to assume responsibility for addressing this problem, especially since the stigma associated with alcoholism has decreased, States have enacted the Uniform Act, and occupational programs have greatly expanded.

ADMINISTRATION PROPOSAL

Mr. Chairman, the Administration supports the objective of alcohol abuse prevention, treatment, and rehabilitation. It would seem reasonable that having made strides toward overcoming the problem of alcoholism and alcohol abuse and having demonstrated alternative approaches to dealing with it, we now must begin to enhance the capacities of the States and localities to deal with the problem at their levels—in the context of the regular community care system, through the Financial Assistance for Health Care Program.

Under our proposal, Federal grantees will be guaranteed—from the States—a percentage for the first 3 years of the program of what they received in 1976 from the Federal Government. Grantees will be guaranteed at least 80% of their FY 1976 grant level in the first year, 50% in the second year and 25% in the third year.

I would now like to briefly discuss the proposal which we are preparing to introduce. It will include the present alcoholism program with a number of other current categorical authorities as part of a single major Administration initiative in the health care area. The implementing legislation is to be known as the Financial Assistance for Health Care Act and is being designed to accomplish the following goals:

Distribute Federal health dollars more equitably to those persons most in need;

Allow each State to set its own priorities for health programs based on the particular needs of its population and its resources;

Give States the leverage and motivation necessary to control rising health care costs; and

Reduce Federal red tape and constrain the growth of Federal employment.

Under our proposal, funds will be distributed to the States according to a formula to be based on the poverty population in the State, per capital income, and the State's tax effort.

The States would be able to spend their allocations for a broad range of services, including those now covered by Medicaid, and other HEW grant programs, for the provision of medical outreach and referral services, for home health aide services, and for living arrangements that would adequately substitute for institutional care.

A major feature of the legislation will be a requirement that States spend at least 90 percent of the funds on personal health care services. The States will set their own requirements as to eligibility and the benefit package but will have to focus their efforts on the poverty population.

A minimum of five percent of the Federal supplement will be earmarked for Community and Environmental Health, specifically for community-based mental health services including alcoholism and drug abuse, and for community health protection—e.g., disease control, environmental health, food inspection, and health education.

We will insert a provision which requires the States to address the following goals in their services plans:

Assurance to all citizens of the State, and particularly chronically underserved populations, of equal access to quality health services;

Development and utilization of preventive health services;

Prevention or reduction of inappropriate institutional care by providing for ambulatory, home-based care or other forms of noninstitutional services particularly for the aged and disabled;

Encouragement of use of ambulatory services in lieu of inpatient services;

The provision of primary care services for medically underserved populations and those which are located in rural or economically depressed areas;

Appropriate, effective and efficient utilization of existing facilities and services;

Promotion of community-wide health efforts.

Within the plans, the States will be required to submit a quantitative assessment of their needs and resources to provide the framework for assuring the efficient and effective use of Federal funds.

Mr. Chairman, I want to stress that we are offering a realistic alternative to the proliferation of isolated, narrow categorical health care progams that we have seen in recent years—programs that are gradually becoming more costly to administer at the expense of the services they are designed to provide—programs that are frequently inappropriate for some local needs and inadequate for others. Therefore, we recommend that this subcommittee support the proposed Financial Assistance for Health Care Act. Accordingly, we are opposed to H.R. 11317. Notwithstanding our basic disagreement with the conceptual approach of H.R. 11317, we must point out that its total annual authorization levels of $188 million are excessive and if the Financial Assistance for Health Care Program is not enacted we would strongly recommend a total authorization level of about $79 million which is consistent with the Persident's 1977 budget and adequate to meet existing Federal commitments to these programs.

CONCLUSION

Thank you very much Mr. Chairman. I greatly appreciate the opportunity to share with you the Department's position.

My colleagues and I would be pleased to try to answer any questions which you or the other members of the Subcommittee may have.

FINANCIAL ASSISTANCE FOR HEALTH CARE ACT—FACT SHEET

The President's FY 1977 budget proposes to improve delivery of health services to the poor by consolidating 16 Federal health programs, including Medicaid, into one $10 billion block grant to States. The proposal, called the "Financial Assistance for Health Care Act," is designed to:

Improve access to quality health care at reasonable cost.

Increase State and local control over health spending.

Control Federal spending, restrain growth of the Federal bureaucracy, and reduce Federal red tape.

Achieve a more fair and equitable distribution of Federal health dollars among States.

The proposal includes a requirement for the development by States of a State Health Care Plan. Public participation in the development of the plan is required to insure that increased State responsibility is coupled with expanded public accounting of State health policies.

Main features of the proposal are listed below. The Administration regards these concepts as the basis for working with Congress, the Governors, and other interested groups with respect to enacting legislation.

I. Programs Included

The sixteen programs shown in Attachment A will be included, effective October 1, 1976. They fall into four major categories: (1) Medicaid; (2) Public Health Service (PHS) preventive and community health programs; (3) health planning, construction, and resources development programs previously subsumed under the National Health Planning and Resources Development Act of 1974; and (4) the developmental disabilities program.

II. Funding Request

The FY 1977 Budget requests $10 billion for the State block grant with $500 million annual increments in Federal funds in future years. An additional $1.5 million in budget authority is requested for program administration costs for an estimated 100 positions.

III. Distribution Formula

After an initial period of transition, funds will be distributed according to a formula giving primary weight to a State's low-income population. The formula gives weight also to the relative "tax effort" made by a State and to a State's per capita income. Under the present system of matching grants and the categorical eligibility structure, some of the States with highest per capita income receive more than four times as much Federal money per poor person as do States with low per capita income. Under this proposal, the poorer States will realize the greatest increases in the share of total Federal assistance.

IV. Phase-in of Formula

A phase-in of the distribution formula will avoid any reductions in FY 1977 below the amounts States are estimated to receive in FY 1976.[1] A gradual phase-in

[1] Assumes enactment of the President's FY 1976 Budget.

will allow States to make the necessary program adjustments. The formula will be applied beginning October 1, 1976, with the proviso that the maximum increase for any State not exceed 10 percent the first year, and that the remainder of the total be distributed so that all States not receiving the full 10 percent realize an equal percentage increase over FY 1976. This will be about 8 percent (8.1 percent). In subsequent years States will move toward the amount allocated by the formula; increases in any year are limited to a maximum of 20 percent over the prior year, and decreases are limited to a maximum of 5 percent. Attachment B shows the distributions of block grant funds in FY 1977 and 1978.

V. Protection for Direct Federal Grantees

To avoid disruptions in health services delivery and insure an orderly, gradual transition to the block grant program, direct Federal grantees (e.g., community mental health centers, neighborhood health centers, and alcoholism programs) will be protected from large budgetary reductions during the first three years of the program. Grantees will be guaranteed at least 80 percent of their FY 1976 grant level in the first year, 50 percent in the second year, and 25 percent in the third year.

VI. State Financial Participation

No State match is required under the block grant program. States and localities spent $16 billion of their own funds for health purposes in 1975 and at least this level of spending is expected to continue.

VII. Reimbursement and Cost-Sharing

States will have broad latitude on reimbursement levels and methodologies, except that payment amounts should be sufficient to assure access to services by the target population. States may impose any level of premiums or cost-sharing they deem appropriate on services.

VIII. Covered Services

1. *Personal Health Care* (minimum 90 percent).—At least 90 percent of Federal funds must be spent on personal health care services. These include a broad range of activities including all services now covered by Medicaid and other grants being consolidated, as well as other health services deemed appropriate by States (e.g., living arrangements that potentially substitute for institutional care). Services currently provided under Medicaid and the PHS grants are listed in Attachment C.

2. *Community and Environmental Health Activities* (minimum 5 percent).—At least 5 percent of Federal funds must be spent for (1) community health protection e.g., disease control, environmental health, health education); (2) community-based mental health services, including alcoholism and drug abuse treatment, and (3) development disabilities programs.

3. *Other Health Activities* (maximum 5 percent).—The remaining 5 percent may be spent on other State-selected health activities including State and sub-State planning, rate regulation, data acquisition and analysis, and resources development. They may also be spent for services in categories 1 and 2 described above.

IX. Target Population and Eligibility

States will have broad discretion in setting income and other standards for defining the eligible population, except that funds must be used to assure that the State's basic health services are provided to low income persons. States are not required to use Federal categorical restrictions in determining eligibility (e.g., childless couples, single persons between ages 21 and 65, and intact families may qualify for assistance), and may deduct out-of-pocket medical expenses in counting income.

States may not impose duration of residence requirements as a condition of participation, or illegally discriminate against service applicants or recipients. Changes in eligibility from existing State standards must be presented for public review and comment as part of the State Plan.

Services financed with the 5 percent community health protection, mental health, and disabilities monies may be offered to all individuals without regard to income.

X. State Plan Requirements

1. A State Health Care Plan must be developed annually as a condition of receiving Federal funds. It will have two major components: Part A will cover the entire State population, both publicly and privately financed health services. Part B will concentrate on the population and services covered by the Financial Assistance for Health Care Act.

The State Health Care Plan should be directed at a minimum, toward achieving the following goals:

Assuring all citizens of the State, and particularly populations covered under the Financial Assistance for Health Care Act access to needed health services of acceptable quality.

Development and utilization of preventive health services.

Prevention or reduction of inappropriate institutional care.

Encouraging the use of ambulatory care in lieu of inpatient services.

Provision of primary care services especially for those located in rural or medically underserved areas.

Assurance of the most appropriate, effective, and efficient utilization of existing health care facilities and services.

Promotion of community health.

2. *Part A Requirements.*—This portion of the State Health Care Plan must include, at a minimum, the following information:

Evaluation of the supply and distribution of State health care *facilities* and *services* (e.g., inpatient, ambulatory, and long-term care);

Assessment of the supply of health *manpower* and manpower training programs;

Analysis of the sources of health *financing* available to State residents (e.g., private insurance, public subsidies); and

Evaluation of the health *needs* of the population, especially those in medically underserved areas (e.g., rural areas).

3. *Part B Requirements.*—This portion of the State Health Care Plan must, at a minimum, include the following:

Definition of the eligible population, including the numbers and categories of individuals to be served (e.g., aged, children). States must provide a rationale for differences in coverage from the plan of the previous year or, from current eligibility standards.

Definition of covered services—including amount, duration and scope—and a rationale for any change from current State programs. (See Attachment C).

An assessment of the health care needs of the target population, and a description of the needs assessment process.

Estimates of individuals to be served and of the expenditures for each service to be provided and each category of individuals to whom services are provided.

Identification of categories of service providers and their distribution by geographic area.

Specification of the standards for each group of providers, explanation of the process for enforcing these standards, and identification of the State agency (agencies) responsible for enforcement.

Description of the methods used to reimburse each category of providers and the levels of reimbursement proposed to be offered.

Assessment of the impact of the services programs on particular populations, including, but not limited to, children, the elderly, migrants, the mentally ill, the developmentally disabled, the handicapped, alcoholics and drug abusers.

Explanation of the mechanisms for program coordination between the State's personal health services program and other human service programs (e.g., Medicare, SSI, Title XX and the overall State Health Planning activity.

Description of a system under which service applicants and recipients may file complaints and receive a fair hearing.

Provisions regarding the safeguarding of information on applicants and beneficiaries.

Definition of the organizational structure responsible for administration of funds provided under the Financial Assistance for Health Care Act.

Description of quality assurance system(s) to be used for each type of provider. A rationale must be presented for any differences from the norms, criteria and standards used for Medicare patients.

Description of the State planning, evaluation, and reporting activities for implementing the Financial Assistance for Health Care Act.

4. *Planning Process.*—An open and public planning process is required in which broad input from health planning organizations representing health interests (e.g., providers, consumers, insurors) at State and sub-State levels is

assured. Both Parts A and B of the State Health Care Plan must be published and made available for public review and comment. State Plan publication, review, and amendment procedures will be monitored by HEW.

IX. Certificate-of-Need

To assure efficient development and distribution of costly institutional health services, States must administer a certificate-of-need program that includes a review and approval or disapproval of new institutional health care services proposed to be offered in the State.

XII. Quality Assurance and Utilization Review

States must have quality of care systems, including peer review of services based on objective norms, criteria and standards.

XIII. Reports and Maintenance of Records

States must submit a report to HEW at the end of each program year which accounts for the expenditure of funds in accordance with the State Plan and explains major variances. States must also maintain records necessary for the proper and efficient operation of the program including records regarding applications, determinations of eligibility, the provision of services, and program expenditures.

XIV. Enforcement, Compliance, Penalties

States must have a mechanism for citizens to file complaints and receive a hearing. In addition, aggrieved citizens may bring civil suit. HEW will track conformity by States to State Plan and Federal requirements and complete an annual financial audit of State records. HEW may hold compliance hearings and terminate all Federal funds when there is both a finding of noncompliance and State refusal to come into compliance or alternatively, reduce Federal payments by up to three (3) percent for each requirement for which a State is not in compliance.

XV. Federal Health Planning Activities

1. *National Council for Health Planning and Policy.*—A National Health Planning and Policy Council will continue to serve as a forum for addressing issues of nationwide concern affecting health care in the U.S. The Council will be composed of representatives of major health interests, including consumers, State and local government providers, insurors, and educational institutions. The Council will address such concerns as (1) health costs; (2) manpower; (3) resources allocation/planning and regulation by States; and (4) the impact of new medical technology on the costs and quality of health care.

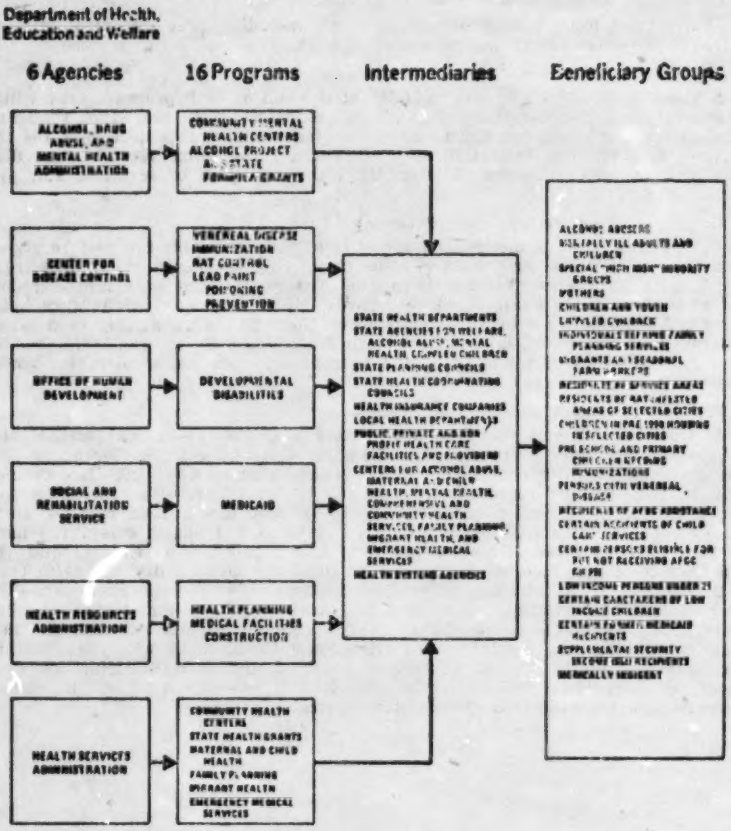
2. *Federal Technical Assistance and Research for Health Planning.*—The Department will continue to develop technical assistance materials, including data, analyses, comparative studies, and guidelines to assist States in their health planning and regulatory activities. The Department will also continue to conduct research on the impact of health planning and regulatory decisions. Finally, HEW will continue its efforts to develop national guidelines describing a more desired distribution of health resources.

ATTACHMENT A

Flow of Federal Health Services Dollars

Before Consolidation

($9.2 Billion in Budget Authority in 1976)



After Consolidation

($10 Billion in Budget Authority in 1977)

ATTACHMENT B

FINANCIAL ASSISTANCE FOR HEALTH CARE, GRANT AMOUNT BY STATE, FISCAL YEARS 1977 AND 1978

[Obligations, in millions of dollars]

	Fiscal year—		
	1976 estimate	1977	1978
Alabama	150.6	165.7	198.8
Alaska	11.1	12.0	11.6
Arizona	12.1	13.3	16.0
Arkansas	107.3	118.0	141.6
California	1,086.2	1,174.6	1,127.6
Colorado	88.9	96.2	100.8
Connecticut	106.7	115.3	110.8
Delaware	12.5	13.7	16.5
District of Columbia	71.7	77.5	74.4
Florida	158.9	174.8	209.7
Georgia	227.5	250.4	300.4
Hawaii	28.3	30.5	29.0
Idaho	30.0	33.0	39.6
Illinois	442.4	478.5	459.5
Indiana	152.4	167.7	184.7
Iowa	83.8	92.2	110.6
Kansas	68.5	75.3	90.4
Kentucky	147.2	161.9	194.3
Louisiana	155.0	170.5	204.6
Maine	62.2	68.4	77.2
Maryland	163.9	177.3	170.2
Massachusetts	341.9	369.7	354.9
Michigan	445.6	481.9	462.8
Minnesota	186.7	201.9	196.6
Mississippi	112.4	123.6	148.4
Missouri	101.1	111.2	133.5
Montana	24.9	27.4	32.9
Nebraska	39.2	43.1	51.7
Nevada	15.2	16.7	20.1
New Hampshire	24.8	26.8	28.2
New Jersey	236.0	255.2	245.1
New Mexico	33.4	36.7	44.1
New York	1,609.2	1,740.2	1,670.5
North Carolina	168.2	185.0	222.0
North Dakota	20.4	22.4	26.9
Ohio	291.9	321.1	344.7
Oklahoma	130.0	143.0	169.3
Oregon	75.6	83.2	96.2
Pennsylvania	436.4	480.0	517.6
Rhode Island	58.5	63.2	60.8
South Carolina	100.0	110.0	132.0
South Dakota	22.4	24.6	29.6
Tennessee	155.4	170.9	205.1
Texas	486.5	535.1	642.2
Utah	37.3	41.0	49.2
Vermont	30.9	34.0	36.2
Virginia	135.2	148.7	178.5
Washington	132.8	143.7	138.0
West Virginia	47.9	52.7	63.2
Wisconsin	266.6	288.3	276.9
Wyoming	7.7	8.5	10.2
Other [1]	42.2	44.3	46.4
Total	9,184.0	10,090.0	10,580.0

[1] Puerto Rico, Guam, Virgin Islands, American Samoa, trust territories.

Note: The share of total Federal assistance going to a State after phase-in is complete is determined by the formula P×TE/PCI. Components are: P, the number of persons in families with income less than 1.5 times the official poverty level, TE, relative tax effort, and PCI, per capita income.

68-861—76——16

ATTACHMENT C—SERVICES NOW COVERED UNDER MEDICAID AND PHS GRANTS

MEDICAID SERVICES

Required

Hospital services (inpatient and outpatient).
Physician services.
Labs and X-ray services.
Skilled nursing facility services for persons over 21.
Screening, diagnosis, and treatment of children (includes outreach and referral services).
Family planning.
Medically-related Home Health Care services.
Transportation to necessary medical care.

Optional

Private nursing services.
Clinic services.
Dental services.
Physical therapy.
Drugs.
Intermediate care facility services.
Mental hospital services for persons over 65.
Prosthetic devices, eyeglasses, and hearing aids.
Inpatient psychiatric hospital services for persons under 21.
Other diagnostic, screening, preventive, and rehabilitative services.
Skilled nursing facility services for persons under 21.
Services of other practitioners licensed under State law.

PHS GRANTEE SERVICES

Community Mental Health Centers.
Alcoholism Services.
Rat Control.
Lead-based paint.
Immunizations.
Venereal disease.
Comprehensive Health Centers.
Family Planning.
Maternal and Child Health.
Emergency Medical Services.
Migrant Health Services.
Health Planning, Construction, and Resources Development.

Mr. ROGERS. Thank you very much.

Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

What you are proposing now, Dr. Cooper, is to consolidate different programs administered by the State. In effect, you would give them a block grant and let them set their own priorities, or would you set their priorities?

Dr. COOPER. No, sir; we would allow them to set their own priorities.

The only other comment I would make on your question is that some of these programs are not currently administered by States; some of them are, in some form or another, as by formula grant. This is an accumulation of 16 specific programs, including medicaid, the total resources of which would be allocated to the States on a formula basis, as I have mentioned, on poverty, per capita income, and so on, and allow the States to set their own priorities basically.

Mr. CARTER. Yes. Concerning mental health centers, of which I believe we have 15 different ones in Kentucky, each one of those has a mental health service which includes treatment for drug abuse and also for alcoholism. Funding for this from now on would be through the States—is that correct—through your block grant?

Dr. COOPER. The proposal would be to require that for the first 3 years that there be an insurance of minimum continuity while the States realine their priorities.

Following that period, their funding would be contingent on other sources of income, including the block grant determined by State priority.

Mr. CARTER. Yes, sir, and——

Dr. COOPER. And there is also in the proposal a requirement that, as I mentioned, there be set aside 5 percent of the total for community services, including community mental health programs, alcoholism, and drug abuse. Ninety percent would be set aside to insure that the money go to personal health services and the remaining 5 percent to other kinds of specific activities, including activities like planning. So we recognize that the community health center, the community mental health center program has dimensions of both personal care and community care. Therefore, the State would have the option and the requirement to address it in both of these dimensions.

However, after the first 3 years, we would not require a specific formula for continuity of a given program; rather, the State would set that within those larger framework provisions.

Mr. CARTER. We have heard a suggestion that the legislation should earmark some $20 million of appropriated money for prevention.

Dr. COOPER. Well, we think prevention is an absolutely essential part of a program for the control of alcoholism. Your administration doesn't support that specific number, as I have already said. However, we do think the high priority should be given to a program in prevention.

Mr. CARTER. What are your ideas on prevention? How would you implement prevention?

Dr. COOPER. Well, prevention in many of these chronic disease and public health areas——

Mr. CARTER. We are talking about alcoholism specifically.

Dr. COOPER. Alcoholism is a particularly complex area, because it has a large amount of social interface with the problem. Although we do consider it a health problem, many of the ways to prevent alcoholism depend on the solution also of other social and economic issues.

For example, we do recognize that when unemployment increases, the tendency toward alcoholism increases, and other kinds of social problems of that kind. So that we cannot look at a total program of prevention in a vacuum here as only a health problem. It is a community problem, and a social, economic, and cultural one as in the point of the special beneficiary population of the Indians.

Now, the specific answer to your question——

Mr. CARTER. Yes; I would like to get to that.

Dr. COOPER. I will try to get to that. I wanted to get to that framework, Dr. Carter, because I think it is important.

First, we have to identify the target populations and specifically try to find out what it is we are trying to prevent in each group; and in each category, it is not necessarily the same.

Second, I think we have to have a sensible program of health education, for example, in the children—as has been started. This is absolutely essential that the life models that these youngsters have learned through other kinds of exposure to media and other home life, and so on, are important to counteract.

I think, in addition, we must develop the criteria to detect on the early signs and medical criteria for abuse, an organ deterioration, deterioration of organ function, and I think from then on, we get into areas of secondary prevention.

Now, I have also written in previous reports, as you are probably aware, that it is probably timely to also discuss what other social actions need to be considered in the sense of the relationship of advertising, the relationship of determining the content of various kinds of beverages that the population is exposed to.

This is not a recommendation for a return to prohibition.

Mr. CARTER. Just prohibition of advertising, is that right?

Dr. COOPER. No, not prohibition of advertising, but a realistic assessment of the propriety of it and the ability of the citizen to make a fair choice. I mean, if he only gets one spectrum of how good it is to imbibe, I am not sure that's a fair choice.

Mr. CARTER. Well, it looks to me like it would not be a fair choice, but rather an invitation.

Have you found the recovery rates for alcoholics are linked to specific forms of treatment?

Dr. COOPER. Well, in reviewing this with the staff, I think that the general feeling that we get is that the treatment specificity is not linked to the recovery rate but the fact that there is treatment, that there are many modes of treatment.

Mr. CARTER. All right, if that is true——

Dr. COOPER. That can be in certain settings.

Mr. CARTER. Is recovery rate related to treatment? I hope it is.

Dr. COOPER. That's right, yes.

Mr. CARTER. What reductions have you made in the rate of alcoholism in the past few years?

Dr. COOPER. Well, I am not sure I can put a firm number on that.

Mr. CARTER. Have we made any reductions or hasn't it gone the other way, really.

Dr. COOPER. I think I would have to break that into two categories.

In dealing with the population which has come under treatment, I think we have made some reductions. In dealing with aggregate numbers of possible abusers, then we probably have not.

Mr. CARTER. There has been an increase in the number?

Dr. COOPER. Probably that is the case.

Mr. CARTER. Of abusers?

Dr. COOPER. But I think we have to not conclude from that that there has been either no effort or no effective effort. I don't know what the increase would have been without a concerted effort.

Mr. CARTER. Well, what about the use of the drug Antabuse?

Dr. COOPER. Well, again this is one mode of treatment which has been around for some period of time which under certain controlled conditions has had some beneficial effect. It obviously is not the answer to the solution of alcoholism.

Mr. CARTER. I will tell you one thing. If you get a person to take it regularly, they will not drink alcohol regularly.

Dr. COOPER. Well, I think you have hit on the point—if you get them to take it regularly. I think that many of us who have dealt with the patients for several of these problems that require chronic consumption of the medication over a long period of time know that it is very difficult to maintain the motivation necessary to accomplish that.

Mr. CARTER. Thank you.

Just one thing. I realize I have talked perhaps more than I should——

Mr. ROGERS. That's all right.

Mr. CARTER. But Doctor, I just want to say that I feel that the social structure of our country must undergo a change, that we must have large playing fields for our youngsters, more supervised recreation. I don't mean just the teams, not just the Washington Redskins, but we must involve all of our youngsters in pursuits of athletic or arts or music or whatever it might be.

I have said this time, after time, after time for 12 years, this is the 12th year, and we are making no effort in this area. I regret that we are not, but if we involve our youngsters and our people, we can avoid a lot of problems.

Dr. COOPER. I subscribe to that, Dr. Carter.

Mr. CARTER. Thank you, sir.

Dr. COOPER. I think this is in the same vein as I was trying to point out, the social interface here. I do think the development of alternative activities and interests for the youngsters in our population is fundamental to this problem.

Mr. CARTER. Well, don't you think really that when we have parties as many of us do here on the Hill, that really we should stop serving hard liquor? Shouldn't we just stop doing those things?

Dr. COOPER. I think the model that the youngster sees as to what success is and what is socially acceptable is an important factor in determining their habits and I think we have to make choices in that regard.

Mr. CARTER. Thank you, sir.

Mr. ROGERS. I understand from your testimony that you feel we have made some progress in the fight against alcoholism and drug abuse?

Dr. COOPER. Yes, sir.

Mr. ROGERS. Is the drug abuse program also covered in the block grant?

Dr. COOPER. No, sir, it is not. It is specifically excluded, and is recommended for some specific new things to implement the recommendations of the Domestic Council, so-called Domestic Council White Paper on Drug Abuse. It is not recommended at this time for inclusion in the block grant.

Mr. ROGERS. Why not similar treatment for alcoholism? I have always thought that alcohol is the most abused drug in the Nation

Dr. COOPER. I would guess it is; yes, sir.

Mr. ROGERS. Is there any disagreement with that statement, doctors?

Mr. ISBISTER. I don't disagree with that statement.

Mr. ROGERS. But you propose the block grant approach for the most serious substance abuse problem but intend to separate the drug abuse problem and keep it here in Washington.

Dr. COOPER. No.

Mr. ROGERS. Why?

Dr. COOPER. Let me try to explain that, Mr. Chairman.

Mr. ROGERS. Yes, I find that hard to understand.

Dr. COOPER. Whereas alcoholism or alcohol may be the most widely abused substance, that doesn't necessarily mean it is the most serious social problem.

Mr. ROGERS. How many deaths are related to alcoholism? It is about 11,000, isn't it?

Dr. COOPER. Well, directly——

Mr. ROGERS. Twelve?

Dr. COOPER. But there are much more that are derivative. I think that is a short number.

Mr. ROGERS. Excuse me.

Dr. COOPER. I think that is a short number I would not debate with you how large the impact could be on the death rate from the direct causes of alcohol itself, the exacerbation of other organ diseases, automobile accidents.

Mr. ROGERS. Family.

Dr. COOPER. Family disruption.

Mr. ROGERS. The public.

Dr. COOPER. All of these—I subscribe to the seriousness of this problem.

Mr. ROGERS. Yes.

Dr. COOPER. I also think that the drug abuse problem and the social setting, as pointed out in that report, is of a different dimension because of its relationship with the criminal justice system, and its relationship with health as well as social activities in that sense.

The President, in my view, in proposing this initiative does not mean to convey—and I think he does by separating out drug abuse—that there is no room for special Federal initiatives and, in fact, by doing it in that way he underscores the idea that we are willing to discuss separate special Federal needs under those criteria.

It is for that reason, I think that the President, feeling that the so-called hard drug problem is so serious, that for the time being it ought to be retained under coordinated Federal direction, whereas some of the other longer existing categorical programs would be ready now for incorporation into a State priority setting mechanism.

Mr. ROGERS. Does this mean we can do a better job in the Federal Government with drug abuse problems than the States can?

Dr. COOPER. Well, I think what the implication here is clearly that for the time being, the program will do better with coordinated Federal supervision than turning it lose at this point in time in the same sense as the other activities.

Mr. ROGERS. Well, that would lead this committee perhaps to believe we should be wary of taking away Federal coordination in the other programs if we can get better results through the coordinated mechanisms of the Federal Government?

Dr. COOPER. Well, I would contend here, Mr. Chairman, that it does not necessarily follow that because one program would fare better that all programs necessarily would thrive in that manner.

Since a relatively modest proportion of their budget is only Federal support, programs with good community support which many of the categorical programs already have, would be in a position to be locally directed with a saving at the Federal level in manpower and administrative costs.

Mr. ROGERS. Is it my understanding that you now feel that programs do not have community support at the local level?

Dr. COOPER. Well, it is our understanding, let me say, from discussion with some of the representatives from State and local govern-

ment, that they feel that they are now both willing and capable of dealing with the administration of these activities in a way more responsive to the needs of their local citizens. They feel that the Federal administration puts on them complicated burdens which are exacerbated by a proliferation of regulations that makes that less efficient than they could do by themselves. It is my understanding from those discussions that this is a sincere thought of the representatives of local government.

Mr. ROGERS. Well then, you feel that any guidelines are unnecessary, useless impediments that the Federal Government places on these programs. Is that the reason the administration wants to change it?

Dr. COOPER. No. I would not conclude personally that the regulations which we write are ill founded, or not directed toward useful or constructive things.

Mr. ROGERS. I would hope not.

Dr. COOPER. No, sir.

Mr. ROGERS. Would the bloc grant eliminate all guidelines or all requirements?

Dr. COOPER. No, sir. Attached to the testimony, as I said, I would direct your attention to the factsheet to the sections on State plan requirements beginning on page 4.

Now, this outlines in section 10 following all the way down through pages 7 and 8 what the requirements for compliance would be.

Mr. ROGERS. How do they vary from present requirements?

Dr. COOPER. Well, the requirement here is to ask the State to define their populations, specific health needs for these populations, how they are going to approach these, require that they be discussed so to speak in the sunshine, require then that they perform according to their own plan, and should they not then perform, then they would be held liable and would be subject to removal of Federal funds for those purposes.

Mr. ROGERS. Isn't that about what we are doing now?

Dr. COOPER. Well, in specific provision we have different dimensions of this, yes. I think in our current programs all of the 17 activities do not necessarily cover all particular felt needs, and I think this committee has heard testimony and will hear more in their hearings on national health insurance about what is not covered, particularly for the disadvantaged populations, that answer being not another set of additional specific categorical efforts, but an opportunity to change the eligibility requirements and to change the benefits package to enable them to go broader, not narrower.

Mr. ROGERS. Does it require broader eligibility?

Dr. COOPER. Well, if you serve more people at the same cost, obviously it will cost more money. If you serve more people more efficiently it need not necessarily cost more money.

Mr. ROGERS. How do you assure efficiency?

Dr. COOPER. Well, I think if we could reduce unnecessary duplication of capital resources, and expensive instruments which in themselves do this, and in changing the incentives for reimbursement so we can pay for what the patient needs rather than for what the insurance policy or the specific program determines, then we can perhaps get at some of these problems of constructive cost containment.

Mr. ROGERS. Do you have such requirements in your proposal? I thought you were going to leave it to individual State determination.

Dr. COOPER. Under section 9, we require a certificate of need; for example, under section 11.

Mr. ROGERS. That's already in present law; is it not?

Dr. COOPER. Yes, but what I am saying is that we will continue to require those kinds of programs, including quality assurance and utilization review.

Mr. ROGERS. Which is also in the current law.

Dr. COOPER. Yes, although not necessarily working as effectively as the Congress and ourselves might like.

Mr. ROGERS. Well you haven't had time. If it hand't been for Federal encouragement, I doubt if many would have ever been established; would you agree with that.

Dr. COOPER. Well, I think to the extent that it is being considered, that would be correct. I think there were jurisdictions quite willing to undertake models.

Mr. ROGERS. A few.

Dr. COOPER. Models before this.

Mr. ROGERS. Well, I see on page 8 that you would distribute Federal dollars more equitably to those persons most in need under the Financial Assistance for Health Care Act. How is that accomplished by a bloc grant to a State?

Dr. COOPER. Well, the exact formula for that, Mr. Chairman, I cannot relate to you in great detail. Some of it is based on the so-called Olshansky data, based in again on the poverty population in the State, per capita incomes, and the tax effort. The idea then would be to assure that those would be the prime determinants of the allocation rather than the other criteria which now determine the match, for example, in medicaid.

Mr. ROGERS. In other words, if a State didn't have an income tax it would be taken into consideration.

Dr. COOPER. I would presume their total tax situation would be a determination.

Mr. ROGERS. Similar to the Reagan plan.

Dr. COOPER. No; it is not the Reagan plan, no sir.

Mr. ROGERS. It would allow each State to set its own priorities for health programs based on the particular needs of its population and its resources. Is this new?

Dr. COOPER. Well, in the sense that States feel that they do not have the flexibility to allocate their resources as they would like. They feel some of the constraints on the categorical programs, as I understand it, requires them, if they want this kind of activity, to have a certain kind of matching allocation. In that sense it is a constraint on their setting of their own priorities.

Mr. ROGERS. In other words, you don't care if the maintenance of State effort continues?

Dr. COOPER. Indeed we do; we want it to increase.

Mr. ROGERS. How can you assure it by lowering the amount of Federal funds they receive and requiring no maintenance of effort?

Dr. COOPER. No; we propose giving them Federal money, Mr. Chairman.

Mr. ROGERS. For 3 years?

Dr. COOPER. No. We propose insisting that they continue the current categorically supported programs while they reassess how they want to do their long-term activity. But we do intend to recommend increasing allocation of Federal dollars to the bloc grant in subsequent years. If my memory serves me correctly, the President recommended in an additional half billion for each of the subsequent 2 years.

Mr. ROGERS. Is that based on projected inflation or some other formula?

Dr. COOPER. It is based on the anticipation that both the population to be served might increase, as well as health care costs will continue to increase, although we would like very much to hope that some of this would be brought under control.

Mr. ROGERS. How do you assure that it would be brought under control?

Dr. COOPER. Well, I cannot assure you that it would be under control. As all of the health proposals in the state of the Union message and in the budget are couched, we really would like to optimistically foresee some curtailment in the rate of escalation rather than absolute control, and those are proposed by the various techniques proposed in the budget.

Mr. ROGERS. Well, then, I presume in these programs you would attempt to control it by placing a ceiling on the amount of Federal dollars.

Dr. COOPER. We control the Federal outlay by that mechanism; yes, sir.

Mr. ROGERS. In other words, no matter what the need might be, you set a ceiling and——

Dr. COOPER. We set a ceiling; yes, sir.

Mr. ROGERS. And disregard the results.

Dr. COOPER. We set a ceiling which would constitute the Federal participation ceiling. It does not mean that we set a ceiling for the total activity.

Mr. ROGERS. I understand that. The State can do whatever it wants to do.

Dr. COOPER. Well, I think there are other participating sources of revenue in the whole health system, one of which is the State, and one of which is the private sector, and the others we expect will continue to participate in it.

Mr. ROGERS. Well, that's the case presently, isn't it?

Dr. COOPER. Yes; it is currently so. We, Federal, and State government, as you are aware, support between 35 and 40 percent of costs in that industry.

Mr. ROGERS. Now the proposed $500 million annual increase would be less than the projected inflationary increase in medicaid alone, wouldn't it?

Dr. COOPER. Yes; according to recent years' criteria, the rate of escalation would be less.

Mr. ROGERS. And do you have any proposals for controlling the cost of medical care?

Dr. COOPER. Well, I think we feel that cost containments in again are dependent on three or four activities that ought to go on in a new proposal such as block grants or in an effective way under current or

new programs, be they no change, modification of existing programs, or even something as extensive as a comprehensive national health insurance proposal. We need to have a system to insure that there is no inappropriate duplication of capital resources in the medical field. There needs to be appropriate, effective monitoring and prohibition of inappropriate or unnecessary utilization of medical resources.

I personally think that the most appropriate system for that rests in a successful PSRO program, as opposed to a UR activity.

And thirdly, I think the incentive system for reimbursement is going to have to be modified progressively in order to allow some of the lower cost things like home health care, ambulatory care, outpatient drugs, rather than forcing institutional care by the forms of the reimbursement proposal.

Mr. ROGERS. But your block grant proposal would not affect those kinds of changes because you let all of those judgments be made by the State, do you not?

Dr. COOPER. Well, the fact that we recommend that the States consider those judgments obviously doesn't consider it as a Federal program of a specific type, although we clearly are giving direction as to what needs to be considered.

I believe we have to start from the proposition that these are honorable men, that we are all concerned in providing better services to the citizens of the country and that they will act responsibly.

Mr. ROGERS. Now, allowing each State to set its own priority for health programs based on the particular needs of its population and resources is exactly the purpose of the Health Planning Act.

Dr. COOPER. Yes, sir.

Mr. ROGERS. That this committee developed in the 93d Congress. It was enacted last January.

Mr. CARTER. If the gentleman will yield on that?

Mr. ROGERS. Yes.

Mr. CARTER. It lets the areas set their priorities, doesn't it?

Mr. ROGERS. And the States.

Mr. CARTER. Well, really and the State, the area itself has priority to a certain extent over the State.

Mr. ROGERS. It lets the local people make their own judgments which I understand is what you want.

Dr. COOPER. That is correct.

Mr. ROGERS. And that is what the bill is intended to do, the President signed it, and the administration supported it.

We require each local area to plan for their needs, and then a State plan is made up from the local proposals. It would set the priority for health programs in that State and in those local areas.

Mr. CARTER. Mr. Chairman, won't your legislation actually form a control for this block grant. Won't it be in charge of expenditure?

Mr. ROGERS. It currently is.

Dr. COOPER. And under our proposal it would not, Dr. Carter.

Mr. CARTER. Sir. It would not be.

Dr. COOPER. Under our proposal we would recommend that one of the programs enfolded into the Financial Assistance for Health Care Act be the Planning Act, Public Law 93–641, but in the requirements for the State plan, the principles that you just enunciated would, in effect, be reimposed in developing this comprehensive activity since, in effect, what you are saying is isn't this the framework against which

we are saying, yes, that should be incorporated into the block grant and then you should carry it out under that.

Now there is a difference. As you will recall, in Public Law 93–641, the local agencies are not under the direct jurisdiction of the State. There are certain relationships which we have heard from you about our regulations, for example, that you think are a little too strong to be interpreted in relationship to the State role, as a matter of fact, rather than the relationship between the local areas and the Department. So there are some differences in intent.

I would not try to deceive you in that regard although the principles enunciated in the Planning Act of what we are trying to accomplish for the allocation of resources and the containment of costs we subscribe to. We think at the present time we should review this decision, in the light of this opportunity to consider this more comprehensive activity.

Mr. ROGERS. Well, are you saying you would not implement the Planning Act?

Dr. COOPER. We will carry out the law as it exists, Mr. Chairman; I want to assure you of that. While these dialogs go on, we will make every effort to implement the act as intended. If the Congress is willing to consider the Planning Act and its inclusion into the Financial Assistance for Health Care Act, we would make every effort to see that the principles and objectives that are forthcoming are included in the specifications for that act.

But, I think you will see when the legislation is finally proposed that, in fact, it involves an exchange for Public Law 93–641 in that it is not continued in its current form.

Mr. ROGERS. How would you give the States the leverage and motivation necessary to control rising health care costs?

Dr. COOPER. Well——

Mr. ROGERS. Aren't these tools in the current planning law?

Dr. COOPER. Well, I think they have plenty of motivation as it is now. As you are quite aware, they are being forced by the current fiscal situation to curtail a great deal of the services in certain States because the costs that they are incurring become prohibitive. I think they have every bit the same stimulation to be concerned as we do.

Mr. CARTER. Mr. Chairman, would you yield on that?

Mr. ROGERS. Certainly.

Mr. CARTER. In many cases I rather doubt that. I regret to say this but many times State jobs depend upon the number of patients, the number of people whom they serve. And some of our employees, for instance, in the Office of Economic Security as we call it in Kentucky, go out and insist that other people come in and take advantage of this. This is why I think HSA is quite, will be quite advantageous because you will have citizens there who are employed by no one, who owe affinity to no one. They themselves will make decisions at the local level as to how that money is to be spent and I believe it will be wisely done.

I have thought for years that we ought to have groups of citizens who should pass on eligibility of a lot of these people.

Dr. COOPER. Well, we think a very important monitor on this system and leverage on this system, as you say, Dr. Carter, is the public, nongovernmental employee, whether it be State or Federal. I think the same principle involved as you are saying—what you intended in Pub-

lic Law 93-641—depends upon that open public discussion, and the involvement of the citizen, the consumer, the provider as well as the governmental employee, whether he be State or Federal. What we are saying here is that we would like you to consider that you could maintain the same leverage of the public on the employee by converting it from the Federal employee to the State employee.

Mr. CARTER. Well, I am beginning to think that this, that HSA legislation is going to have a very beneficial effect on the administration of legislation coming under the purview of your office. Certainly I hope it will.

Mr. ROGERS. I think so too.

Now, you say your plan will reduce Federal red tape and constrain the growth of the Federal bureaucracy.

Dr. COOPER. That is our hope.

Mr. ROGERS. Well, now, how do you intend to check all of these State plans that you have added here. It looks to be about the same level of activity as we are undertaking now. Who would check it?

Dr. COOPER. Yes, sir, we will obviously have to have an administrative staff to check this, and in the President's budget, there were identification of employees necessary for that. I would say that until all of the specifications are out, I would be better able to discuss this in great detail as to specific activities when the program is complete.

It is expected that since there are changes in grants management and in several of those kinds of things that the number of Government employees would be less, but we obviously would have to continue a relationship with them.

Mr. ROGERS. Although you basically can't make any determinations for them.

Dr. Cooper. That is correct.

Mr. ROGERS. Aha. And could you let us know how many fewer employees would be needed in the Federal Government?

Dr. COOPER. We would give you an estimate of that. I have a draft. I do not have it with me, but we will provide you with that.

Mr. ROGERS. If you could put that in the record for us.

[The following information was received for the record:]

ESTIMATE OF POSITIONS THAT COULD BE ELIMINATED IF FINANCIAL ASSISTANCE FOR HEALTH CARE LEGISLATION IS ENACTED

Listed below is an estimate of positions that could be eliminated if the Financial Assistance for Health Care legislation were enacted, along with associated dollar costs. This estimate includes full-time equivalent of other positions as well as permanent positions.

It is estimated that approximately $54.4 million would be saved from the elimination of full-time permanent positions and the equivalent of other positions. These savings would be offset by $1.5 million for positions to manage the new block grant program, resulting in a net savings of approximately $52.9 million.

Below is a table which identifies the position and dollar reductions associated with the block grant proposal.

1977 BLOCK GRANT PROPOSAL

	Full-time permanent positions	Full-time equivalent of other positions	Dollars (in millions)
Health Services Administration	−619	−15	−8.7
Center for Disease Control	−413		[1] −7.0
Alcohol, Drug Abuse, and Mental Health Administration	−175	−40	−6.5
Health Resources Administration	−367		−6.3
Subtotal, PHS	−1,574	−55	−28.5
Medicaid	−816		−24.3
Developmental disabilities	−61		−1.6
Total reduction	−2,451	−55	−54.4
Assistant Secretary for Health	+100		+1.5
Net reduction	−2,351	−55	−52.9

[1] Amounts are based on average GS salaries identified in the personnel summary of the President's budget.

Dr. COOPER. For the entire block grant proposal, I believe it is a reduction of about 2,000 people, but I will get that number for you.

Mr. ROGERS. Now, when will the legislation be submitted?

Dr. COOPER. Again, do you have a State date?

Mr. HAISLIP. No, we don't have a date. I suspect it would be perhaps 2 or 3 weeks, not much longer than that, certainly.

Mr. ROGERS. This committee will look at it when it is introduced.

Now, I think it would be well though in case the committee decides not to pass it that you also give us the estimates of monies necessary to support the programs we are considering today.

Dr. COOPER. As I have said in my testimony, Mr. Chairman, in the event that the committee does not consider the program appropriate, on the bottom of page 11 I have recommended that we continue the authorization at a level consistent with the President's budget level for 1977, which is about $79 million.

Mr. ROGERS. And that amount is a component of the block grant?

Dr. COOPER. It is reflected in the block grant, but I would call your attention also in the block grant that in the group that is called the medicaid add-on the estimate for medicaid is between $9.1 and $9.2 billion. The add-on package or the lump in is $10 billion. Therefore, there are in addition to the whole level figures from 1976 from the President's request, an additional $800 or $900 million that would be available for adjusting programmatic needs in various allocations.

Mr. ROGERS. What has been the comparison of the moneys appropriated and spent in these same categories? What would those totals be over the last 5 years?

Dr. COOPER. Mr. Isbister?

Mr. ROGERS. Certainly.

Mr. ISBISTER. Mr. Chairman, I don't have the figures going back 5 years but I will provide them for the record.

Mr. ROGERS. Yes, full, please.

[The following information was received for the record:]

The specific sections of the law now authorizing alcohol community project grants and contracts were enacted in FY 1975. Previously the Community Mental Health Center authorities were used. The following table provides a five year history denoting the appropriate legislation.

APPROPRIATION AND AUTHORIZATION HISTORY, ALCOHOL COMMUNITY PROGRAMS

[Dollars in thousands]

	Funding section	1972 actuals		1973 actuals		1974 actuals		1975 actuals		1976 appropriations		1977 present budget	
		Authorized	Appropriation	Authorized	Appropriation	Authorized	Appropriation	Authorized	Appropriation	Authorized	Appropriation	Authorized	Appropriation
Community assistance: staffing grants: (CMHC's Act)	261	(1)	7,670	(1)	11,700	(1)	10,051	(1)	10,423	(1)	10,097		
	203e												
Project grants and contracts: (CMHC's act)	261	60,000	5,584	80,000	3,[illegible]	36,744	11,505					(1)	
	247	40,000	24,939	50,000	50,000	50,000	50,000						
(Public Law 91-616 as amended)	311							80,000	51,806	95,000	55,549	(2)	[3] 30,905
Grants to States: (Public Law 91-616 as amended)	301	60,000	30,000	80,000	60,000	80,000	45,600	80,000	52,000	80,000	55,500	(2)	45,600
Special grants (uniform act): (Public Law 93-282)	304							13,000	2,679	13,000	2,762	13,000	2,546
Total appropriation			68,193		125,578		117,156		116,908		123,908		[3] 79,051

[1] Sums as necessary.
[2] Expired.
[3] In addition, the 1977 President's budget proposes $12,000,000 for Indian alcohol programs to be administered by the Indian Health Service. In fiscal year 1976 and prior years, funds for these programs were administered by ADAMHA and are included in this table. The Indian alcohol grants are not proposed for inclusion in the health block grant.

Mr. ISBISTER. The fiscal year 1975 appropriation for alcohol community programs, including staffing grants, was $116.9 million. The amount contained in the Appropriation Act enacted by the Congress was $123.9 million in fiscal year 1976. This compares with $79 million in the 1977 budget, plus $12 million for Indian alcohol programs.

Dr. COOPER. And that was vetoed.

Mr. ISBISTER. That is the act that was vetoed.

Mr. ROGERS. Yes. So, the Congress appropriated more than was requested.

Dr. COOPER. Yes, sir.

Mr. ROGERS. From 117 to 124. But you pick up at 79.

Dr. COOPER. Yes, sir.

Mr. ROGERS. And this will give what, 80 percent of what they have been receiving?

Dr. COOPER. Approximately.

Mr. ROGERS. And then it goes down to what?

Dr. COOPER. Sixty and fifty.

Mr. ISBISTER. Fifty and twenty-five.

Dr. COOPER. Fifty and twenty-five, excuse me.

Mr. ROGERS. Fifty and twenty-five?

Dr. COOPER. Yes, sir.

Mr. ROGERS. Now, what happens if a State can't match those funds? What if a State like New York were having financial difficulties.

Dr. COOPER. We will have not made a requirement that the State match.

Mr. ROGERS. So you anticipate that if they don't have the money they would close programs?

Dr. COOPER. Well, let me read from page 2 of the supplement under No. 6. State Financial Participation. No State match is required under the block grant program. States and localities spent $16 billion of their own funds for health purposes in 1975, and at least this level of spending is expected to continue.

But I have no way of assuring you under this proposal that they will continue to match any specific category by current formula. The purpose is just the opposite, to allow them the flexibility to do that as they wish or not at all.

Mr. ROGERS. And has any analysis been made as to what projected services will be closed?

Dr. COOPER. I do not have such an analysis. There are studies going on now. I do not know if it answers that particular question, Mr. Chairman. I would be glad to forward to you what we have on that, if you so desire.

Mr. ROGERS. Well, I think this would be a most important consideration for this committee. If what you are proposing simply closes services, I think we should know that, and to what degree we might anticipate it and I presume if you go from 80 percent to 25 percent in support, you will have a rather significant number closed.

Dr. COOPER. No, it doesn't mean that in that form, Mr. Chairman. What we are saying is that there is no reason why from our standpoint that the activities support should necessarily decrease at all during this period of time. However, recognizing that in certain States their activity in alcoholism or in any of the other categorical activities may be poor operations, inefficient, unnecessary, if by chance that the

State would have the option of terminating that just as we do on occasion for an inappropriate or ineffective project.

On the other hand, that provision is not to set a level of activities for those 3 years but just to insure that they are continuing to think of the continuity of those periods during that period of time. There is no requirement that they reduce the activity and no necessary anticipation that any given State would set say alcoholism as a low priority item. They may indeed elect to increase the allocation for alcoholism.

Mr. ROGERS. But, then other service would be decreased if they increase their alcoholism allocation.

Dr. COOPER. Well, I don't know that any service would be cut out, although in some States, as you are seeing now, things like the provision of optometric care or false teeth or other things are being gradually pruned from some of the public service programs.

I cannot, I do not know, and I don't know how we could anticipate at this point in time what States would eliminate or increase what services.

Mr. ROGERS. Well, we have State plans.

Dr. COOPER. Well, we would have after we saw the plans, yes, sir.

Mr. ROGERS. We have State plans in current law. Hasn't HEW insisted that the law——

Dr. COOPER. You mean in medicaid?

Mr. ROGERS. I mean in State health plans.

Dr. COOPER. Well, in the Comprehensive Health Planing Act.

Mr. ROGERS. Well, of course, that preceded the present planning bill.

Dr. COOPER. Yes.

Mr. ROGERS. They were to have submitted plans; I presume you had them do that. If not, your predecessors did, I hope.

Dr. COOPER. Well, if one scrutinizes those that I have had the pleasure of seeing, I don't think we can extract from it that kind of specific data in numbers, because as you are well aware from the discussions we had prior to the consideration of Public Law 93–641, the comprehensive planing activity was quite uneven and not uniform across the country. Therefore, comprehensive plans rarely reflected State activity reports rarely reflected the kind of specific data that we wanted to get even under 314D. So I think we have a ways to go in being able to provide that and in that sense the requirement for a new comprehensive plan, with the specific data as pointed out under the plan requirements here, will help us in planning that kind of evaluation.

Mr. ROGERS. Well, I think this committee should have some knowledge as to what will happen to existing health services if we pass this type of program.

Mr. CARTER. Mr. Chairman.

Mr. ROGERS. We have to account to the taxpayers for Federal expenditures; not just let it go out and be unable to tell what is happening.

Yes?

Mr. CARTER. I certainly agree on that. I don't know, I don't believe this question has been asked, at least I have not heard it.

How do these authorizations in H.R. 11317 compare with authorizations for the preceding 3 years?

Dr. COOPER. They are the same as the fiscal year 1976 authorization.

Mr. CARTER. They are less?

Dr. COOPER. Mr. Isbister can give you the specific details for the record.

[The following information was received for the record:]

The specific authorizing legislation for project grants and contracts was not enacted in fiscal year 1975. The authorized levels compared with those proposed by H.R. 11317 are as follows:

	Fiscal year—			
	1974	1975	1976	1977 (H.R. 11317)
Sec. 311		$0, 000, 000	$5, 000, 000	$5, 000, 000
Sec. 301	$0, 000, 000	0, 000, 000	0, 000, 000	0, 000, 000

Mr. CARTER. And we are not requiring the States to put up any matching funds, is that correct?

Dr. COOPER. That is correct. The block grant does not require specific matching funds. We expect that they will continue to support total health services in their States by as much or more contribution than they have in the past and that they would not terminate. I have to take as an article of their interest in people, as is ours, that they are not interested in terminating productive, important service.

Mr. CARTER. Of course on medicaid do you intend to continue the same formula as you have with different States?

Dr. COOPER. No, sir.

Mr. CARTER. You don't?

Dr. COOPER. No, sir. We mean to have a different formula that would be determined, and this would be a shift, two differences. One is that there would be not matching requirements for the whole package, including the medicaid program. The same statements would obtain what I just said.

And second, the total block of grants of Federal money, the $10 billion that are included, would be determined by the poverty population, the income per capita, and the tax effort of the State.

Mr. CARTER. You would require a State contribution, would you not?

Dr. COOPER. No, sir.

Mr. CARTER. Not for medicaid.

Dr. COOPER. For nothing.

Mr. CARTER. Well, at the present——

Dr. COOPER. And a State, the statement is on section 6.

Mr. CARTER. Well, what about——

Dr. COOPER. We expect that they will, and we hope that they will, continue to contribute the $16 billion or more, but we will not propose a legal requirement that they do so.

Mr. CARTER. Up to this time hasn't the Federal Government been providing approximately 75 percent of this and the States about 25 percent?

Dr. COOPER. Well, our estimates, I think you would see here, Dr. Carter, would be somewhat less, not for the whole package. We think we are providing in this category about $10 billion, whereas the States are providing about 16, so it is a little less than half.

Mr. CARTER. Well, our State I think the percentage is much larger.

Dr. COOPER. Some States are much larger and some are smaller.

68-861—76——17

Mr. CARTER. Yes, sir.

Mr. ROGERS. But there would be no variance between States under the block grant?

Dr. COOPER. Yes, no, no.

Mr. ROGERS. You have a formula.

Dr. COOPER. There would be variance based on the poverty population, per capita income and the tax effort.

Mr. ROGERS. But not necessarily the need.

Dr. COOPER. Well, if you consider that the need is primarily focused on the disadvantaged population, there is a relationship to need, but it is not determined by specific categorical disease need.

Mr. ROGERS. Well, alcoholism afflicts more than just the poverty population.

Dr. COOPER. Yes, there are——

Mr. ROGERS. Doesn't it?

Dr. COOPER. Yes; I think some of the activities in alcoholism obviously impinge on all strata of society and that is why the proposal does not say only disadvantaged population. It says primarily focused on it. There are other categories that we will discuss tomorrow, and major medical services which is another category with other unique special relationships. So we won't want to again necessarily exclude any type of special Federal relationship, but we want to get at the problem of how to efficiently allow local priority setting in this health service category.

Mr. CARTER. Mr. Chairman, on that I won't say it cuts straight across the social stratas at all. It has been shown that the poor and those who are unemployed imbibe more, I believe. Recent statistics show that, do they not?

Dr. COOPER. Yes; I think statistics show that.

Mr. CARTER. Yes, sir, it is so. If what I read in the newspapers is correct.

Dr. COOPER. Well, I just wanted to make sure that evedybody didn't go away with the notion that the affluent didn't drink.

Mr. CARTER. Well, I know some that consume quite a lot or seem to.

Mr. ROGERS. Well, I am concerned that the Congress must have some mechanism to account for the funds we spend. We are held accountable when we go up for election. And I have some concern about simply turning over funds to governmental bodies who have no responsibility or accountability for raising the funds. I am not sure that this is a very good principle to establish—that you hold one body acconntable for raising the funds and they have to explain the tax bite, but then you give them no responsibility as to how the funds are to be spent. Instead you let another governmental body, which has nothing to do with raising the money, spend it.

Is that a good governmental principle; does OMB really believe that? Now I know you can't speak for them.

Dr. COOPER. I can't speak for OMB. But, I speak here for the President rather strongly if I may and that is that the President is not interested in nonaccountability. He is very interested that the public dollars be spent efficiently and effectively and this is at the heart of his whole fiscal program. And on a very serious thought, I think that he is interested in accountability and effective use there.

On page 7 we do require reports and maintenance of records and we do think that the real bottom line, as you are going to keep asking

us program after program, under any form, is whether the people are getting any better or the health of the Nation is getting any better and as we reported to you recently, I think we are making progress. So there are forms of accountability.

The other point I would make is that it is not that different a proposal, I think, in many respects vis-a-vis this issue as other forms of revenue sharing.

Mr. ROGERS. Which I voted against, you might be interested in knowing. I have great concern about the principle of just turning over $30 billion in revenue sharing.

Mr. CARTER. Well, Mr. Chairman. There is much to be concerned about. Some people think it is manna from heaven when actually they have contributed to it.

Mr. ROGERS. It is their own money.

Well, I know we will be going into this further in the future.

I think we have gotten the thrust.

Dr. COOPER. We will have another item tomorrow that is also for inclusion.

Mr. ROGERS. Yes, well that will be fine.

Now is there anyothing that should be said about the alcoholism program on the part of those who are administering it?

Mr. ISBISTER. I think Dr. Cooper did a good job, Mr. Chairman, of summarizing some of the accomplishments that we wanted to present to the subcommittee.

Mr. ROGERS., What are the failures?

Mr. ISBISTER. I will speak to that briefly and perhaps Dr. Noble will take it from there.

I think that in any program you never make progress quite at the rate that you want to. Our concern ultimately is for the kinds of outcomes that Dr. Cooper was talking about with Dr. Carter, that is to say, what is happening to the problem within the country in terms of rates of alcoholism.

Mr. ROGERS. Yes. Let me ask this. Are there any States where they are still putting alcohol abusers in jail without real treatment and follow-up?

Mr. ISBISTER. Well I think one of the great——

Mr. CARTER. Yes, Mr. Chairman, I can attest to that.

Mr. ISBISTER. But I think that one of the great accomplishments of the Federal effort is working with people at the State and local level as Dr. Cooper referred to earlier. Mr. Chairman, the fact that some 25 or 27 States have now adopted the Uniform Alcoholism Act, the much greater attention to the problem within the health and medical community, the recognition of alcoholism as a health problem, the treatment of alcoholism outside the criminal justice system, are all areas where we have made remarkable progress in the last few years.

Mr. ROGERS. Now, how many have adopted the Uniform Act within the last 2 years.

Mr. ISBISTER. Have enacted the uniform act?

Mr. ROGERS. That we know of.

Dr. DEERING. An additional 20 States.

Mr. ROGERS. Twenty in the last 2 years?

Dr. DEERING. Yes, either in its basic entirety or in a somewhat modified form. There are now approximately 35 or 36 States which have some form of the uniform act on their books.

Mr. ROGERS. Do they? But only 27 have descriminalized alcoholism.

Dr. DEERING. No, I am sorry, 25 States have enacted the uniform act almost in its entirety and a further 10 or 11 States have adopted a somewhat modified version of it, but basically in agreement with the major principles of it.

Mr. ROGERS. As a health problem?

Dr. DEERING. Yes.

Mr. ROGERS. In other words, they don't throw people in jail.

Dr. DEERING. No.

Mr. ROGERS. So we have about 30 some odd now.

Dr. DEERING. About 35, yes.

Mr. ROGERS. What other problems exist?

Dr. NOBLE. Are you asking me?

Mr. ROGERS. Yes, Doctor.

Dr. NOBLE. Well, as I see it, I have come at the time in the Institute's history when there is a tremendous momentum generated and an awareness, but I think we have just barely scratched the surface when you talk about issues and problems in our country. There is a tremendous increase of alcohol abuse in our children, and it is a problem I am sure of great concern to all of us here.

There is, I think, an increased incidence, for example, of alcohol abuse in terms of its effect. The 9 million figure that we have given, I am not sure that that is correct as of today. So we are going to have to see the incidence of that and the epidemilogical data. I have a hunch that is probably a bit on the rise. I think we have by no means stemmed the tide.

So to answer your question in terms of problems, there are problems generated. There are about 3 million women alcoholics in our country, but again we are not sure of that number because a lot of them are what we call cryptic alcoholics or in the home and we have to devise methods to try and find these people and then render them help.

We have problems that have come up with research in terms of an alcoholic syndrome where women who drink alcohol when they are pregnant have defective babies. I think these are problems coming to our attention as more research is being done in this field.

So I think there are a great many problems yet in front of us.

First I would like to see the tide being stemmed. I like to see evidence that our drinking is coming down and the abuse problems in alcoholism but I don't have the feeling yet of that.

Mr. ROGERS. Do we have enough trained personnel to deal with the problem?

Dr. NOBLE. That is a problem also. We would hope that more people would become trained at the State and the community level. We are doing our share to stimulate that, especially alcoholic counselors—and not so much perhaps in terms of people to be trained de novo, from the start, but we are trying to get people who already have had some involvement and get them into the alcohol field.

Mr. ROGERS. And would you let us have for the record your suggestions or the Institute's suggestions as to what should be done in the area of prevention.

Dr. NOBLE. I will be happy to.

[The following information was received for the record:]

PREVENTION OF ALCOHOLISM PROGRAM

Let me first point out that the prevention of alcoholism is very complex. We are not dealing with an illegal drug, or even one which is harmful if used in moderation. Therefore, we do not suggest abstinence, but rather a concept of responsibility. This concept has many facets, for example, the prevention of long range medical problems, loss of job and family, traffic fatalities, etc.

As a new Director, I would like to see the prevention of alcohol abuse made a priority among the National, State and local organizations. Youth educational programs on the responsible use of alcohol should be expanded. Prevention programs, in the early recognition of alcohol problems and responding to the needs of alcohol abusers, should also be promoted. I would like to see the prevention components of existing treatment and rehabilitation projects expanded. More research relevant to the development of better prevention programs should be pursued. In addition, more evaluation should be conducted on the different prevention techniques in order to assess their effectiveness for certain communities. Also, I would like to develop greater public awareness of alcohol abuse and alcoholism through our National Clearinghouse for Alcohol information and other prevention efforts.

Our prevention program attempts to focus on all of this and to emphasize certain areas according to certain communities. Although the prevention efforts is most complex and challenging, it remains an area where the potential rewards are the greatest.

Mr. ROGERS. What are the most significant programs that have developed—have you encouraged activities in one State to be used by other States, for instance?

Dr. NOBLE. I think we are just getting into that. John perhaps could answer more of the specifics.

Dr. DEERING. Yes, a number of our demonstration projects I think, have encouraged other States to mount somewhat similar programs. We are currently spending some $10 to $12 million a year on a range of activities and I think we are just beginning to see some of the payoffs from those.

Mr. CARTER. Mr. Chairman.

Mr. ROGERS. Yes.

Mr. CARTER. On that, already you are spending some $10 to $12 million a year for what?

Mr. ROGERS. Demonstrations.

Mr. CARTER. Demonstrations?

Dr. DEERING. For all of our prevention activities, broadly defined, yes.

Mr. CARTER. Such as what?

Dr. DEERING. We have got quite a considerable sum of money in our youth and community education activities.

Mr. CARTER. Where do you conduct these——

Dr. DEERING. These are——

Mr. CARTER [continuing]. Educational activities.

Dr. DEERING. These are conducted at the local grass roots level. A lot of them are channeled through such organizations as the PTA, the Education Commission for States, et cetera—through the school systems and through the universities and colleges.

Mr. CARTER. Thank you, sir.

Dr. DEERING. Jaycees.

Mr. CARTER. There is one other question. About how many patients do you have, do you treat in 1974 under the alcoholism program?

Dr. DEERING. Our latest figures are for 1975. Total patient contacts are estimated as being slightly under a quarter of a million from our alcoholism community treatment project grants.

Mr. CARTER. You treated 250,000?

Dr. DEERING. About a quarter of a million.

Mr. CARTER. You treated that many people? Of that number, what was your rate of recidivism?

Dr. DEERING. We have just concluded an 18-month followup, and we hope to have shortly the results of a 3-year followup on a random sample of this population. We find that we have had a fairly good recovery rate in about 70 percent of the population passing through our programs.

Mr. CARTER. You have a 70 percent?

Dr. DEERING. Yes.

Dr. COOPER. Good rating—not recidivism.

Mr. ROGERS. Thirty-percent recidivism.

Dr. COOPER. Thirty percent.

Mr. CARTER. That is the best I have ever heard.

Dr. COOPER. We don't want to oversell that. It is a short-term project.

Mr. CARTER. I would like to see hard statistics to that.

Dr. DEERING. We will be glad to submit a copy of that.

Mr. ROGERS. If you will submit that for the record, that would be helpful.

[The following information was received for the record:]

Study findings from a sample of 1,329 clients entering treatment in our NIAAA funded Alcoholism Treatment Centers (ATC) revealed that 70% were significantly improved at eighteen months after first contacting the program. Forty-six percent of the clients studied were abstinent. Seventy percent had reduced their level of drinking below one ounce of pure ethanol per day, including the abstinent group. In addition, an employment increase of 16% was reported for ATC clients in the labor force with a corresponding 41.9% increase in monthly earned income.

Dr. DEERING. I think one of the most encouraging things is changes in the levels of employment over unemployment, if you like, the decline in unemployment that is going on within our programs, the decline in the use of other inpatient facilities, and also the decline in the levels of impairment among the populations which are being treated.

Mr. ROGERS. All right.

Any other suggestions or anything that the committee should know?

If not, thank you for your presence.

The hearing is adjourned.

[The following statements and letters were received for the record:]

STATEMENT OF JAMES C. RICE, ADMINISTRATIVE DIRECTOR, MANHATTAN BOWERY PROJECT

My name is James C. Rice, Administrative Director of the Manhattan Bowery Project, 8 East 3rd Street, New York, New York 10003.

The Manhattan Bowery Project was founded in November, 1967, by the Vera Institute of Justice. It was originally conceived as a criminal justice diversion project and has evolved into the major comprehensive alcoholism treatment program for disaffiliated alcoholics in the City of New York. The Project is a not-for-profit corporation with a distinguished Board of Trustees from all walks of public

and private life. Both the Trustees and the Project's staff are dedicated to the principle that disaffiliated alcoholics, or public inebriates, are entitled to high caliber treatment and rehabilitative services. The Project's goal is to strive to eliminate the punitive and repetitive arrest procedure to which disaffiliated alcoholics have been subjected in the past and to provide for the medical, social and vocational needs of alcoholism's most severely afflicted population.

Following the Project's opening in 1967, arrests for public intoxication on the Bowery declined sharply. Today, such arrests are virtually non-existent. The Project has served as a model for other communities throughout the country. Visitors representing health care providers and law enforcement agencies have come to observe how the Project operates. An increasing number of states are decriminalizing public intoxication, New York among them, and establishing programs similar to the Project's as a humane alternative to incarceration. Since its inception, the Project has benefitted from the wholehearted cooperation of the New York City Police Department's Criminal Justice Division which contributes staff to the Project. This cooperation between a top law enforcement agency and an experienced health care and social services provider is an ideal model for other local communities to follow.

The Project presently operates five major program components:

Street rescue teams manned by plainclothesmen and Project rescue aides.

A 48-bed out-of-hospital inpatient alcohol detoxification unit.

An alcoholism outpatient clinic.

A 14-person long-term Supportive Residential Therapeutic Environment program (STEP).

A 15-person work-oriented therapeutic residence called Project Renewal.

The single most unique feature of Project operations is the street rescue team. Two teams are presently in operation, one in the Bowery area of Manhattan and the second in the New York City Police Department's 20th Precinct. Driving an unmarked police vehicle, the teams patrol the Bowery and Manhattan's West Side three or more times every day on the lookout for alcoholics who are inebriated, withdrawing, severely debilitated, or about to experience trauma, such as convulsions or delirium tremens. The team returns to the Project with only those men who wish to accompany them voluntarily or summons an ambulance, if required, for acute emergencies. If medical help is not desired by the prospective patient, the rescue team will offer other assistance to men on the street such as moving them to safety or returning them to their homes. In the City of New York, disaffiliated alcoholics are no longer restricted to the Bowery area but frequent virtually all areas of the five boroughs. Demands on the part of local communities for a rescue team to patrol their area have multiplied over the past year. The Project has responded to such requests with offers to formulate plans for a rescue team serving local neighborhoods.

The Project's inpatient unit is a haven for those persons in medical need and the gateway to the treatment system. Patients admitted to the unit receive medical care, psychiatric consultation and evaluation, counselling, social services and referral to aftercare facilities. The substantial number of referrals to aftercare can be attributed in large measure to the positive and hopeful atmosphere, created by staff, which prevails on the inpatient unit. The referrals to State hospitals, alcoholism rehabilitation units and residential facilities increased ths past year, reflecting a prefrence on the part of disaffiliated alcoholics for a decent roof over their heads rather than living in Bowery flophouses while attending the Project's outpatient department.

A great number of people using the Project's outpatient department are making substantial progress in spite of the outpatient clinic's limited size and capability. 54% or 201 of 317 men seen in the clinic during the past year had one or more months of continuous sobriety. 18% or 70 of 371 men had six or more months of continuous sobriety. 62% or 233 of 371 did not have to return to the inpatient unit for detoxification more than once during the entire year. The Project is proud of this record with an especially difficult population.

Occupational alcoholism programs use the possibility of job loss as a lever to induce employees to seek treatment for alcoholism. After alcoholics have lost all else, such as family, home, friends and life savings, a job and steady earnings constitute the last vestige of self-respect. By the same token, a job and steady earning are of equal significance to alcoholics, such as those the Project serves who are without them.

This principle is the foundation upon which Project Renewal was established. Bowery alcoholics enrolled in the year-long program, most of whom have had little or no recent work experience, have found a regularly paid work routine

cleaning and maintaining 90 City playlots to be of significant benefit to them in achieving sobriety and regaining self-respect. The work routine combined with individual and group counselling, recreational activities, and education, is of substantial value to Project Renewal's trainees as they strive to reenter society's mainstream.

The Project's Supportive Therapeutic Environment Program, known as STEP, is the only program of its kind for recovering alcoholics in the City of New York. It is situated on the sixth floor of a single room occupancy hotel on Jane Street in Lower Manhattan. STEP houses 14 male residents, who may remain in the program up to a maximum of six months. The men enroll in the City's public assistance program, become involved in local community affairs, and take part in on-site supportive services. Recently, graduates of STEP who chose to remain at the hotel could select a room on another floor of the Jane-West Hotel where an alcohol-free community has taken shape. These men formed a self-governing Transitional Residence and banded together in order to maintain their sobriety gained while in the STEP program.

In addition to the foregoing operating components, the Project is about to embark upon the establishment of two new innovative components on Manhattan's West Side, serving an area from 38th to 94th Streets, Central Park west to the Hudson River, including the Pennsylvania Station/Madison Square Garden, the Times Square, the New York Coliseum and Lincoln Center areas. A non-medical detoxification unit serving 35 to 40 people at any one time for an average 5–7 day stay and an associated intermediate-term residential rehabilitation program serving 19 people will soon be in operation. Community acceptance of these two program components has been remarkable. There is a general recognition on the part of an enlightened and educated West Side community that treatment and rehabilitation services for the disaffiliated alcoholic are a necessity. Community residents are willing to have these two programs in their midst because they provide hope for the hopeless among them.

The Manhattan Bowery Project is funded through the National Institute on Alcohol Abuse and Alcoholism, the New York City Department of Mental Health and Mental Retardation Services, the New York State Department of Mental Hygiene, and the New York City Department of Employment/Manpower and Career Development Agency. The Project gratefully acknowledges this support and cooperation. Without it, the Project would cease to function. Countless individuals in both official and unofficial capacities have come forward during this past year to express their belief in the work of the Manhattan Bowery Project at a time of fiscal crisis. The Federal, State and City governments all have been outspoken in support for the work which the Project has done and is continuing to do with disaffiliated alcoholic people.

The quality of life in the City of New York depends on agencies such as the Project to be able to offer viable and constructive alternatives to helpless people, people who not only are a visible scar on the face of the City, but those who, by virtue of the nature of their affliction, are not always well received by some helping agencies. A treatment staff dedicated to restoring the well-being of men and women who are so afflicted is critical to treatment outcome. The Project has assembled such a staff, one which manages to avoid becoming cynical and downtrodden when confronting the same patients over and over again. This unique ability to sustain enthusiasm can be attributed in large measure to the policy of the Manhattan Bowery Project to employ graduates of its program components in order that they may impact a sense of hope and initiative to the patients with whom they come into contact. The positive effect of helping others who, like themselves at one time, find themselves victims of the most insidious disease known to man, helps the helpers to build a genuine sobriety and to give a very special meaning to their work.

This work must continue. The Federal, State and City agencies whose prime concern it is to provide services such as those offered by the Manhattan Bowery Project, must continue to work in concert with one another as they have only just begun to do. This is a must if we are collectively to wage combat in the fight against despair, hopelessness and excruciating death. The Manhattan Bowery Project holds out hope for the disaffiliated alcoholic people of this country. The Project must count on the resources of government in order to carry on its valuable work. This work is not only valuable to the recipients of the service but to the community and the country at large. It cannot and must not be neglected. Adequate resources must be devoted to its continuance if there is to be hope for the future.

EDUCATION COMMISSION OF THE STATES,
Denver, Colo., January 21, 1976.

HON. PAUL G. ROGERS,
Chairman, Subcommittee on Public Health and Environment,
Rayburn House Office Building,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: On behalf of the Education Commission of the States (ECS) Task Force on Responsible Decisions About Alocohol, I would like to indicate our interest in the renewal of legislation that authorizes the current federal alcoholism program administered by the National Institute on Alcohol Abuse and Alcoholism. These programs and authorities are clearly needed on a continuing basis, and we are pleased that you have introduced H.R. 11317.

This ECS task force has a concerned interest in placing a high national priority on the prevention of alcohol-related problems. There are certainly many opinions about how these problems can be prevented or minimized. The enclosed document attempts to summarize the points about which there is widespread and common agreement. Hopefully, this document can be helpful to you and your subcommittee as you consider the need for an active, nationwide effort to address alcohol-related problems.

During the last two years, the task force has been meeting with numerous organizations and individuals from the public and private sectors to develop recommendations on planning and delivering primary preventive educational programs in our nation's states. Preliminary reports have been prepared by the task force and are enclosed for your information. A final report of these findings will be available in late 1976.

If we might provide your subcommittee with additional information, I would very much appreciate hearing from you. Again, may I express our appreciation for the attention you are giving to this matter of great national concern.

Sincerely,

JOHN C. WEST,
Former Governor of South Carolina and Chairman, Education Commission of the States Task Force on Responsible Decisions About Alcohol.

THE NEED FOR HIGH PRIORITY FOR ALCOHOL ABUSE AND ALCOHOLISM PREVENTION EDUCATION

The problems of alcohol abuse and alcoholism have existed throughout most of civilized history. They are tenacious and devastating problems that continue to exact an intolerable toll in terms of human suffering, social disruptions and economic losses.

It is easy to reach agreement that the massive health impairments, accidental deaths, family problems, economic loss and the other tragic problems of alcohol abuse and alcoholism must be reduced. The precise methods of achieving this, however, have been illusive; and it has become clear that these problems do not have a single cause and do not lend themselves to single solutions. It is, therefore, obvious that reducing the problems related to alcohol abuse and alcoholism require a multifaceted approach.

In recent years research in these matters has been increased, and we have increased, somewhat, our understanding and knowledge of alcohol abuse and alcoholism. Much of what has been learned has also served to confirm the complex nature of alcohol abuse and alcoholism and convinced us that a multifaceted program of research must be continued and expanded.

The wisdom of providing treatment and rehabilitation services to alcoholic people is now beyond question. There is always room for improvement, but successful alcoholism treatment methods are known and have the potential to recapture much of the human potential we have historically lost to alcohol abuse and alcoholism. It is vital that the federal thrust toward making high quality treatment more widely available be continued and expanded. Far too few alcoholic people have reasonable access to alcoholism treatment services, and extending the authorities of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 is essential.

The important programs of research, training and treatment leave one issue unsettled. Realistically, we know that the age-old problems of alcohol abuse and alcoholism are not going to stop occurring among future generations unless we take some kind of preventive action now. Even with a diligent effort now, these problems are not going to disappear. So the real and honest question for the next

few years is how to reduce the potential for harm—how to promote the kind of respect and concern for one's self and others that will lead people to responsible decisions about alcohol and an understanding of alcohol abuse, alcoholism and related problems. Admittedly, there are many problems whose relationship to the use or misuse of alcohol is not fully understood, and we must continue to research these matters. But our obligation to future generations is to use what knowledge we have gained in recent years. It is far more effective and less costly to prepare an individual to avoid or cope with problems than to have society remedy these problems after they occur. Thus, there is an urgent need for a major prevention effort to supplement the important programs of treatment, training and research that continue to be required.

Many organizations and individuals have concluded that there are only two responsible decisions about alcohol: not to use it, or to use it responsibly. While millions of Americans have made responsible decisions regarding the use or nonuse of alcohol, our society as a whole has yet to develop clear and consistent guidelines for decision making—guidelines that reflect attitudes and behaviors of both responsible drinking and responsible abstaining. This nation continues to pay the staggering costs associated with the misuse of alcoholic beverages.

The critical need for preventive educational efforts is a natural outgrowth of the last ten years. The first major national priority in the field of alcohol abuse and alcoholism was in research, which reflected the concern about the psychopharmacology of alcoholism. This concern gave rise to the accompanying priority for treatment and rehabilitation services of the alcohol abuser, alcoholic person and the family. However, even though we know that alcohol problems result from a complex interplay of physical, psychological and sociocultural factors, insufficient emphasis has been given to the social and cultural factors that influence by appropriate and effective preventive education that promotes responsible decisions about alcohol that lead to less harm to the individual and society.

The skills and attitudes necessary to make responsible decisions can be identified and learned. What must now be developed are the guidelines, educational services and systems for delivering the services and programs that will give people the information and learning experiences needed to develop and maintain these skills. Only by positively shaping societal attitudes and by helping individuals develop the means by which the harmful consequences related to the misuse of alcohol can be averted or reduced can we expect to minimize alcohol-related problems and their associated costs.

Public policy to develop a consensus among our nation's people that promotes proper attitudes, teaches responsible decisions about alcohol and strengthens healthful living behaviors is needed at all levels of society. It must then be endorsed, encouraged and implemented by a vast array of local, state and national representation, including family and community, business and industry, religious organizations and educational and political leadership.

The following needs are clearly identifiable:

(1) Throughout this country there is a growing awareness of and enthusiasm for the potential that the concept of prevention might offer. While this enthusiasm is reinforced by promising efforts to date, there is a clear need to establish a higher priority for preventive education in order to move toward an effective nationwide prevention program.

(2) While at present there exists a well-documented pool of knowledge and, in general, adequate materials for dissemination, there is a need for additional research to further supplement the data base about alcohol abuse, alcoholism and the concept of prevention.

(3) There is a need to develop action plans to capitalize on existing knowledge and readiness in order to demonstrate the feasibility of programs that emphasize individual skills and attitudes as a method of contributing to the reduction of problems related to alcohol abuse and alcoholism.

(4) There is a need to develop new and effective systems of delivering this knowledge and information through collaborative efforts at the local, state and national levels. The problems and needs that must be addressed to minimize alcohol abuse and alcoholism cannot be made by a single agency but must involve family and community, business and industry, religious organizations and educational and political leadership.

(5) Demonstration and training programs that utilize varying educational services and delivery system techniques are needed to provide for effective prevention efforts. These should be done in a variety of settings, such as correctional institutions and public schools and should enlist the support and involve-

ment of local communities. Such an effort would provide information, over an extended period of time, to determine which combinations of total educational services and delivery systems are most effective.

(6) There is a great need to provide technical assistance and consultation to to states regarding prevention alternatives for developing and delivering services. Such assistance is not now readily available. The states are asking: what can be done and how? This need must be met.

(7) State responsibilities and effective programs for prevention can be increased through federal-state partnerships. For example, prevention must be included in comprehensive state planning through formula grants.

The National Institute on Alcohol Abuse and Alcoholism has motivated and coordinated efforts designed to prevent alcohol abuse and alcoholism. There is urgent necessity of this agency increasing its commitment to that goal. A long-term commitment and effort is required.

(8) Specific and definitive legislative policy needs to be established to provide for funds to carry out programs and to assure that these needs and commitments are met.

AMERICAN NURSES' ASSOCIATION, INC.,
Kansas City, Mo., January 27, 1976.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Health and the Environment, House Interstate & Foreign Commerce Committee, Rayburn House Office Building, Washington, D.C.

DEAR MR. ROGERS: The American Nurses' Association supports the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation proposal (HR 11317) which provides for the extension of authorities for formula grants to states, special grants for the implementation of the uniform alcoholism and intoxication treatment Act and project grants and contracts for the prevention and treatment of alcohol abuse and alcoholism.

These extensions represent an important part of comprehensive health care and a segment of care which was too long overlooked. We believe the extension of federal assistance in this area remains a priority to enable programs at the community level to continue. Only within recent years has alcoholism been recognized as a health problem. Many families and individuals with whom nurses work still see this disease as a social disgrace which acts to inhibit and thwart prevention and treatment attempts. At a time when there is reportedly an increase in alcohol use among adolescents and when alcoholism affects more than nine million Americans we must continue to improve programs. It seems almost certain that state and local governments would find funding cuts for alcohol abuse and treatment programs very difficult to cope with in these tight budget times.

Nurses form a very active and vital cadre of health professionals involved in prevention and treatment programs. Occupational health nurses and community health nurses, as well as school nurses, are very much involved in case finding, referral, health education and psychological support for both the individual and the family.

We are pleased that you are holding hearings on this bill and we urge the extension of these programs. We hope these comments are helpful and ask that they be made a part of the hearing record.

Sincerely,

EILEEN M. JACOBI, ED.D., R.N.,
Executive Director.

AMERICAN HOSPITAL ASSOCIATION,
WASHINGTON OFFICE,
Washington, D.C., January 29 1976.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Public Health and the Environment, Committee on Interstate and Foreign Commerce, Rayburn House Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: On behalf of the American Hospital Association comprising some 6,000 hospitals and other health care institutions, I am pleased to submit the following comments in support of your bill, H.R. 11317, a three-year extension of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

The Association has for many years recognized alcoholism and addiction to drugs as medical problems requiring broad-scale attack. Programs for the prevention of alcoholism, while difficult, are important. Our "Statement on Admission to the General Hospital of Patients with Alcohol and Other Drug Problems" calls on hospitals to accept a community responsibility for the appropriate admission of persons acutely ill as a result of alcoholism, and also the responsibility for the timely referral of these persons to specialized and/or after-care treatment centers. We have urged general hospitals to develop and implement plans and programs for the care of persons suffering from alcohol abuse and have conducted intensive programs aimed at the expansion and improvement of the capability of hospitals to care for patients suffering from alcoholism.

The Association believes hospitals should be prepared either to treat within their own resources alcohol and other drug abuse patients who are suffering from medical conditions requiring treatment, or if the hospital does not have the necessary treatment capability, it should have a functioning plan for the immediate referral or appropriate transfer of such patients. We helped to get such a requirement for general hospitals included in the standards of the Joint Commission on Accreditation of Hospitals.

Mr. Chairman, we applaud your efforts to support and extend this vital federal initiative. Governmental activities coupled with significant support in our voluntary health care institutions are making important contributions to educational, clinical and research aspects of this most debilitating disease. It is essential that we coninue to commit resources to combat alcoholism and to find more successful methods to restore its victims to a healthy and productive life. In view of the many other demands on our federal health care dollars, we believe your funding recommendations represent a reasonable and responsible maintenance of effort in this area.

Thank you for the opportunity of presenting these views to your Committee. We would appreciate having this correspondence included in your permanent hearing record.

Sincerely,

LEO J. GEHRIG, M.D.,
Senior Vice President.

INTERNATIONAL MEDITATION SOCIETY,
Washington, D.C., January 30, 1976.

Hon. PAUL G. ROGERS,
Chairman, House Subcommittee on Health and the Environment, Rayburn House Office Building, Washington, D.C.

MR. CHAIRMAN: I have a professional degree in social work specializing in addictions, and I have knowledge through study and work experience of most of the treatments for alcoholism. Many of these treatments are of potential value, if the alcoholic has the psychological capability to use them. One program that does seem to help the alcoholic develop those capabilities is the Transcendental Meditation (TM) Program.

Over the last four years, I have become involved in the Transcendental Meditation Program myself, and I am now a qualified instructor of the tecnique. I have personally taught this technique to alcoholics, and I know other alcoholics who do this practice. The following are comments taken from case histories of alcoholics in a study at the Wisconsin Division of Vocational Rehabilitation.

(1) Subject 4, a 47-year-old male alcoholic: "I, as an alcoholic, found that staying sober after my divorce was a constant struggle following each confrontation with my ex-wife. However, after beginning and continuing TM for several months, it has reached a state where situations that once drove me to the brink of resuming my drinking pattern no longer tempt me to use alcohol as an escape. I feel that TM has helped give me the strength to sanely cope with heretofore upsetting conditions."

(2) Subject 5, a 42-year-old female alcoholic: "Among the benefits I have personally noticed as a result of meditation are a greatly increased feeling of self-assurance and general well-being."

(3) Subject 7, a 56-year-old male alcoholic: "It has been my experience as an alcoholic that after practicing TM for a few months my tendency to 'fly off the handle' over relatively inconsequential things has been greatly reduced. Things still do happen but they don't bother me. I have found that I have also gained a greater degree of tolerance for others and have also become less impatient."

(4) The therapist commented on Subject 11, a 35-year-old male alcoholic, that TM seems to have helped him overcome a serious block which he had toward making use of the program of recovery of AA. When he began TM he was overtly hostile to AA; today he is on the steering committee of one of the local clubhouses.

(5) The therapist commented on Subject 14, a 40-year-old female alcoholic, that she stated that TM helped her to be more assertive in not drinking even in the company of drinking friends, and of lowering her anxiety level to the point where staying sober has been much easier.

This growing strength, self assurance, and inner control is what the alcoholic needs most so that he may have the phychological capability to benefit from other programs in recovering from alcoholism.

TM is a simple, natural mental technique that allows the mind to settle down and the body to gain a deep state of rest. It involves neither religion nor philosophy and so does not run counter to the beliefs of the alcoholic even if he is not ready to give up the use of alcohol. Many alcoholics will learn this technique because of its popularity in the general public. The TM technique as taught to alcoholics is identical to that which is taught the 30–40,000 who learn in the general public each month, and there are over 400 centers of the TM program which have free followup and support programs for mediators, without reference to alcoholism or other stigma.

Research studies in different laboratories over the past five years also suggest that the TM Program would be beneficial for the treatment and prevention of alcoholism and alcohol abuse. The results of a large retrospective study by Benson and Wallace were published in 1971. 1,862 people who had been practicing TM for different lengths of time were asked to answer a questionnaire concerning alcohol usage. In the six-month period before starting TM, 60% of the subjects took hard liquor; and, of these, approximately 4% were heavy users. After 21 months of practicing the TM technique, only 25% took hard liquor, and 0.1% were heavy users.[1]

A carefully controlled study conducted by Shafii, Lavely, and Jaffee (1975) comprised 126 TM subjects and 90 matched control subjects. No control subjects reported discontinuation of beer and wine use. 40% of the subjects who had practiced the TM technique for more than two years had discontinued use of beer and wine within the first six months. After 25–39 months of the TM technique this figure increased to 60%. In addition, 54% of this group versus 1% of the control group had stopped drinking hard liquor.[2]

The findings of these studies have been verified in part or all by Barutigam, 1971;[3] Otis, 1973;[4] Shafii, Lavely, and Jaffee, 1974;[5] and Schwartz, 1973.[6]

These scientific investigations of the TM Program do not prove its worth, but they do indicate fundamental and pervasive benefits: reduction in tension and anxiety,[7] greater self control and increased self assurance,[8] and enhanced sense of well-being.[9] Each of these benefits has tremendous value to the alcoholic.

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[1] Benson, H. and Wallace, R. K. Drug Abuse. Proceedings of the International Conference, Philadelphia, U.S.A. Lea and Febiger, pp. 369–376, 1972. Congressional Record, Serial No. 92–1 (U.S. Govt. Printing Office, Wash., D.C., 1971.).

[2] Shafii, Mohammad and Lavely, Richard, and Jaffe, Robert. Meditation and the Prevention of Alcohol Abuse, *American Journal of Psychiatry*, Vol. 132, No. 9, pp. 942–945, September 1975, U.S.A.

[3] Brautigam, E., The Effect of Transcendental Meditation on Drug Abusers, Research Report, City Hospital of Malmo, Sweden, December 1971.

[4] Otis, L. S. Meditation or Simulated Meditation by Non-Predisposed Volunteers: Some Psychological Changes. Paper presented at American Psychological Association meeting, Montreal, 1973.

[5] Shafii, M., Lavely, R., and Jaffee, R. Meditation and Marijuana. *American Journal of Psychiatry*, Vol. 131, No. 1, pp. 60–63, January 1974, U.S.A.

[6] Schwartz, G. E. Pros and Cons of Meditation: Current Findings on Physiology and Anxiety, Self-Control, Drug Abuse and Creativity. Paper presented at American Psychological Association meeting, Montreal, 1973.

[7] Ferguson, P. C. and Gowan, J. The Influence of Transcendental Meditation on Anxiety, Depression, Aggression, Neuroticism and Self-Actualization. *Journal of Humanistic Psychology* (in press) U.S.A.

[8] Fehr, T., Nerstheimer, U., and Torber, S. Study of 49 Practitioners of Transcendental Meditation with the Freiberger Personality Inventory. *Scientific Research on Transcendental Meditation: Collected Papers*, Orme-Johnson, D. W., Domash, L. and Farrow, J. (Eds), Vol. 1, Los Angeles, MIU Press, 1974, U.S.A.

[9] Van den Berg, W. P. and Mulder, B. Psychological Research on the Effects of Transcendental Meditation on a Number of Personality Variables Using the NPI. *Scientific Research on Transcendental Meditation: Collected Papers*, Orme-Johnson, D. S., Domash, L. and Farrow, J. (Eds), Vol. 1, Los Angeles, MIU Press, 1974, U.S.A.

These are the psychological qualities that will help him find greater success and happiness and thereby undercut the need to reach for any artificial stimulant whether alcohol or other drugs.

In order to conquer alcoholism, the treatment must effectively strengthen the intrinsic rewards of life while sober and do so in a way that will be acceptable to the alcoholic. The TM technique is learned in four days, about two hours each day, and is then practiced 15–20 minutes twice daily without interfering with any other work, study, or therapy which the alcoholic might want to be involved with. It requires no machines, drugs, or continual and expensive meetings with a therapist. It is one practice the alcoholic can do on his own to stay sober longer.

Respectfully,

JOHN R. BEAN, M.S.S.W.,
7115 Leesburg Pike,
Falls Church, Va.

P.S. For further clarification, I am pleased to direct you to the Institute of Social Rehabilitation of the World Plan Executive Council, at 1015 Gayley Avenue, Los Angeles, CA 90024.

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., February 13, 1976.

HON. PAUL ROGERS,
Chairman, Subcommittee on Public Health and Environment, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, Washington, D.C.

DEAR MR. ROGERS: The American Medical Association would like to take this opportunity to offer its support for H.R. 11317, a bill to extend for three fiscal years programs of assistance under the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

H.R. 11317 would extend assitance to States to assist in planning, establishing, maintaining, coordinating, and evaluating projects for the development of alcohol prevention, treatment, and rehabilitation.

In addition, funds would be authorized for each of three fiscal years for support, respectively, of programs for State implementation of the Uniform Alcoholism and Intoxication Treatment Act and for the prevention and treatment of alcohol abuse and alcoholism. The AMA participated in the development of this model state legislation and has encouraged its adoption.

We believe that the problem of alcoholism in this country has been, and remains, a serious health concern. Alcoholism has long been recognized by the medical profession as being both a disease and a form of drug dependence.

Pursuant to this recognition, the House of Delegates of the American Medical Association issued in 1966 and revised in 1971 a Policy Statement on Alcoholism. The 1971 revision stated, in part:

> That the American Medical Association identifies alcoholism as a complex disease with biological, psychological and sociological components and recognizes medicine's responsibility in behalf of affected persons . . .

In addition, in recognizing the need for a high priority in the allocation of services, facilities, and funds in order to help achieve a desired goal of concentrated national efforts directed toward the problems of alcoholism, the AMA supported the original Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970. The AMA believes that this Act has resulted in positive steps toward facing the problems of alcoholism in this country.

Alcoholism is a complex disease with profound impacts upon society. It is our belief that continuation of the existing programs which would be fostered through this legislation is essential. Therefore, we urge that H.R. 11317 be supported as a continuation of the national efforts to alleviate the problems caused by alcoholism.

Sincerely,

JAMES H. SAMMONS, M.D.,
Executive Vice President.

[Whereupon at 11:30 a.m., the hearing adjourned.]

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